

The newsletter of
Ireland's focal point
to the EMCDDA

drugnet IRELAND

Issue 70 | Summer 2019

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Drug-related deaths 2004– 2016

The latest figures from the National Drug-Related Deaths Index (NDRDI) show that a total of 736 deaths in Ireland during 2016 were linked to drug use.^{1,2} The NDRDI reports on poisoning deaths (also known as overdose), which are due to the toxic effect of a drug or combination of drugs, and on non-poisonings, which are deaths as a result of trauma, such as hanging, or medical reasons, such as cardiac events, among people who use drugs.

Key findings of the report are:

- Prescription drugs contribute to the majority of poisonings and were implicated in 258 or three in every four poisonings during 2016.
- Taking a cocktail of drugs (polydrugs) continues to be a significant factor in poisoning deaths.
- Alcohol remains the main drug implicated in poisoning deaths, alone or with other drugs.
- Hanging is the main cause of non-poisoning deaths.



Dr Gregor Burkhart
of the European
Monitoring Centre
for Drugs and Drug
Addiction (EMCDDA)
speaking at the National
Drug Education and
Prevention Forum
2019w, which was held in
Dublin in June

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The policy, research and other documents covered in this issue of *Drugnet Ireland* have all been retrieved by the HRB National Drugs Library and may be accessed on its website www.drugsandalcohol.ie

In brief

While research and health-related issues have been given some attention in the public debate around Brexit, they have struggled to gain attention in the heated discussion around trade, free movement, and judicial oversight. A recent paper¹ by a group of public health academics has attempted to highlight the damaging effect that the severing of links with agencies such as the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) and Europol will have on the UK's capacity to deal with the consequences of illicit drug use. They point out that continued access to EU-generated information and intelligence is not guaranteed in a post-Brexit situation.

The recent increase in cocaine-related deaths and the dangers posed by organised crime's participation in the distribution of extremely dangerous synthetic opioids underline the importance of access to the timely and accurate data made available through participation in the EMCDDA's network of national drug monitoring centres. Recent advances in tackling drug-related organised crime in Scotland through multiagency collaboration has been dependent on access to good-quality epidemiological and supply information. As the trade in illicit drugs is by its nature international and largely hidden, linking this information to the wider European picture is essential if decisions are to be based on evidence.

The EU Early Warning System on new psychoactive substances has been highly successful at detecting new drugs, accurately describing their characteristics and potential dangers, and sharing this information effectively so that the knowledge gained through this system can inform the response of all member states. The recent re-establishment of Ireland's Early Warning and Emerging Trends network allow us to contribute and learn from this rich source of information.

Through its participation in the EMCDDA, the UK has made a significant contribution to our understanding of the European drugs situation and its implications for public health and security and the capacity of member states to respond quickly to new developments, identify and implement responses supported by evidence, and evaluate policies and strategies. Severing this link with European institutions may well have public health and security consequences and cause lasting damage to the UK's ability to manage these harms.

1 Roman-Urrestarazu A, Yang J, Robertson R, McCallum A, Gray C, McKee M and Middleton J (2019) Brexit threatens the UK's ability to tackle illicit drugs and organised crime: what needs to happen now? *Health Policy*, 123(6): 521–25.

Drug-related deaths, 2004–2016

continued

In the 13-year period from 2004 to 2016 inclusive, a total of 8,207 drug-related deaths were recorded by the NDRDI. Of these deaths, 4,597 (56%) were due to poisoning and 3,610 (44%) were non-poisoning deaths.

There were 736 deaths in 2016, similar to the number reported in 2015 (735) (see Table 1). Many of these deaths were premature, with one-half of all deaths in 2016 aged 42 years or younger. Three in four (549) of all deaths in 2016 were male. In 2016 alone, 21,300 potential life years³ were lost because of drug-related deaths (see Figure 1).

Deaths in 2016 among people who inject drugs

People who were injecting at the time of the incident that led to their death represented 5% (34 deaths) of all drugs-related deaths in 2016. The majority were male, involved opiates (85%) and two-thirds (65%) occurred in Dublin city (see Figure 2).

Poisoning deaths in 2016

The annual number of poisoning deaths decreased slightly from 365 in 2015 to 354 in 2016 (see Table 1). As in previous years, the majority (69%) were male. The median age of those who died was 42 years.

Key findings of poisoning deaths in 2016:

- The number of deaths involving alcohol increased by 18% from 112 in 2015 to 132 in 2016. Alcohol was implicated in over one in every three poisoning deaths (37%) and alcohol alone was responsible for 16% of all poisoning deaths.
- Opiates were the main drug group implicated in poisonings; methadone was implicated in almost one-third (29%) of poisonings, while heroin-related deaths decreased for the third year in a row from 96 deaths in 2014 to 72 in 2016 (see Figure 3).
- Prescription and/or over-the-counter drugs were implicated in seven in every 10 (73%) poisoning deaths.
 - Benzodiazepines were the most common prescription drug group implicated. Diazepam was the most common benzodiazepine-type drug and was implicated in one in four (96; 27%) of poisonings.
 - Methadone was the most common single prescription drug, implicated in 103 (29%) of poisonings.
 - Pregabalin (an anti-epileptic drug also prescribed for neuropathic pain and generalised anxiety disorders) was implicated in 65 deaths in 2016, an increase from 49 deaths in 2015, with a persistent rise from 14 deaths in 2013.
- Cocaine-related deaths decreased from 45 in 2015 to 41 in 2016.

Table 1: Number of deaths, by year, NDRDI 2004–2016 (n=8207)

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
All deaths (8207)	431	502	554	620	629	655	607	644	661	707	726	735	736
Poisonings (4597)	266	300	326	386	387	371	339	377	356	400	370	365	354
Non-poisonings (3610)	165	202	228	234	242	284	268	267	305	307	356	370	382

Figure 1: Infographic of all drug-related deaths in 2016



Figure 2: Infographic of all deaths among people known to be injecting at time of death in 2016



Drug-related deaths, 2004–2016

continued

Figure 3: Infographic of poisoning deaths in 2016

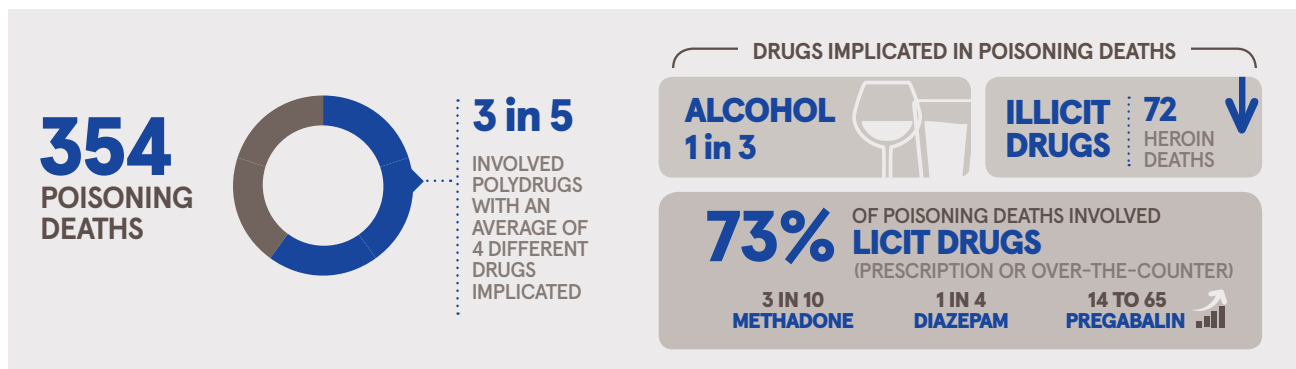
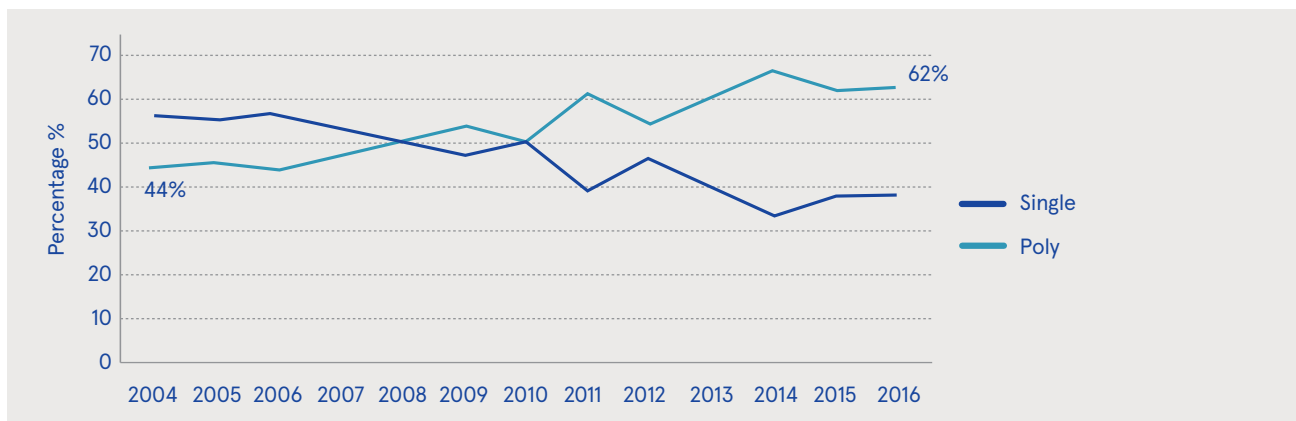


Figure 4: Evolution of polydrug poisonings, NDRDI 2004–2016 (n=4597)



Polydrug poisonings in 2016

Taking a cocktail of drugs (polydrugs) can increase the risk of fatal overdose. The majority of poisoning deaths (62%) in 2016 involved polydrugs, with an average of four different drugs taken (see Figure 4).

- 58% (77) of deaths where alcohol was implicated involved other drugs, mainly opiates.
- 88% (91) of deaths where methadone was implicated involved other drugs, mainly benzodiazepines.
- 81% (58) of deaths where heroin was implicated involved other drugs, mainly benzodiazepines.
- All diazepam-related deaths (96) involved other drugs.

Non-poisoning deaths in 2016

The number of non-poisoning deaths increased slightly with 382 deaths in 2016 compared with 370 in 2015. Non-poisoning deaths are categorised as being due to either trauma (172 deaths) or medical causes (210 deaths).

- The main causes of non-poisoning deaths categorised as trauma were hanging (93; 24%) and those categorised as medical were cardiac events (56; 15%).
- Three in every four (75%) people who died as a result of hanging had a history of mental health problems.
- The median age for deaths due to medical causes has increased from 38 years in 2004 to 46 years in 2016, which may indicate an ageing cohort of people who use drugs in Ireland.

Ena Lynn

- 1 Health Research Board (2019) *National Drug-Related Deaths Index 2004 to 2016 data*. Dublin: Health Research Board. <https://www.drugsandalcohol.ie/30174/>
- 2 A number of infographics that outline key data are also available for download as well as tables outlining breakdown by county and DATFA (Drug and Alcohol Task Force Area). For further information, visit: www.drugsandalcohol.ie/30174 and www.hrb.ie/publications
- 3 Potential life years lost was calculated by looking at the age of individuals who died in 2016 and what their life expectancy would have been based on their year of birth.



The organisers of the National Drug Education and Prevention Forum 2019, which was held in Dublin in June. L to R: Angela King, Richie Stafford, Tara Deacy, Mary Heffernan, Ciara Faughnan and Trevor Bissett.

POLICY AND LEGISLATION

Ministerial segment of 62nd session of Commission on Narcotic Drugs

The Commission on Narcotic Drugs (CND) is the governing body of the United Nations Office on Drugs and Crime (UNODC). Essentially, it is the central drug policymaking body of the United Nations (UN). It aims to provide member states and civil society with the opportunity to exchange expertise, experiences, and information on drug-related matters and to develop a coordinated response to the drug situation. Membership is made up of representatives from 53 UN member states, allowing for a spread of geographical representation. Ireland is not currently a member.

In March 2019, representatives from UN member states and civil society met in Vienna for the 62nd session of the CND. As well as plenary sessions, there were approximately 100 side events held.¹ However, a much-anticipated two-day ministerial segment took place at the start of the session; it is this element of the session that is the focus of this article.

Ministerial segment

The *Political Declaration and plan of action on international cooperation towards an integrated and balanced strategy to counter the world drug problem* was adopted by CND in 2009.² The Political Declaration includes measures to enhance international cooperation, identifies problems and areas requiring further action, as well as goals and targets in countering the world drug problem. The year 2019 was set as the target date for member states to 'eliminate or reduce significantly and measurably' five target areas: the illicit cultivation; illicit demand; illicit production, trafficking and use of internationally controlled substances; the diversion of precursors; and money laundering (p. 14).² The two-day ministerial segment, added to the regular CND session, was convened to take stock of the implementation of the commitments made in that declaration. It included a general debate as well as two interactive, multi-stakeholder round table meetings that were conducted in parallel. One focused on the question of taking stock of implementation, by analysing existing and emerging trends, gaps, and challenges. The other focused on strengthening international cooperation, including means of implementation, capacity-building, and technical assistance, on the basis of common and shared responsibility.

A ministerial declaration was agreed as part of the segment, 'strengthening our actions at the national, regional and international levels to accelerate the implementation of our joint commitments to address and counter the world drug problem'.³ It is beyond the scope of this article to detail the wide variety of commitments made in the declaration but, broadly speaking, it does not represent any fundamental change in UN drug policy from that which has emerged over the last decade. It makes an ongoing commitment to achieving the 'operational recommendations and aspirational goals'³ set out in the 2009

Political Declaration, the 2014 Joint Ministerial Statement on the review by CND,⁴ and the 2016 UNGASS outcome document.⁵ It also commits to deliver on the Sustainable Development Goals 2030.

The declaration presents a bleak picture of the 'persistent and emerging challenges related to the drug problem', noting, for example, 'record levels' in the abuse, illicit cultivation, production, manufacture and trafficking of narcotic drugs and psychotropic substances. While these persistent challenges are seen by many commentators as an indication of a failure of the current policy framework to achieve the goals set out in the 2009 document, the members make an ongoing commitment 'to actively promote a society free of drug abuse'.³ There is also a pledge to review progress in implementing the international drug policy commitments in 2029, with a mid-term review in 2024.

Responses to the Political Declaration

The declaration has drawn criticism from civil society stakeholders. It is seen to represent some progress towards a more health and human rights-based approach, especially in its commitment to the UNGASS outcomes document and the Sustainable Development Goals 2030. However, it is not deemed to have gone far enough in that direction and away from a more punitive approach. The International Drug Policy Consortium (IDPC) sees this and the ongoing commitment to the 'damaging drug free goals' to mean the declaration 'has once again stifled progress in UN drug policy'.⁶ The Eurasian Harm Reduction Association (EHRA) expressed concern that by continuing to focus on a 'society free of drug abuse', this will result in the ongoing 'persecution of people who use drugs' and is incompatible with ensuring basic human rights.⁷ The lack of any 'genuine and honest evaluation' of the impact of international policies on delivering on the targets as laid out in the 2009 Political Declaration was also heavily criticised.⁶ This was seen as indicative of a lack of willingness on the part of member states to admit that punitive and repressive policies have failed in the attempt 'to eradicate the global illicit drug market'.⁶

Lucy Dillon

- 1 A blog of many of the sessions is available at: <http://cndblog.org/>; the full programme for the session is available at: https://www.unodc.org/documents/commissions/CND/2019/2019_CND_PROGRAMME/Programme_CND_2019.pdf
- 2 United Nations Office on Drugs and Crime (UNODC) (2009) *Political Declaration and plan of action on international cooperation towards an integrated and balanced strategy to counter the world drug problem*. Vienna: UNODC. <https://www.drugsandalcohol.ie/30219/>
- 3 UN Economic and Social Council (2019) *Draft ministerial declaration on strengthening our actions at the national, regional and international levels to accelerate the implementation of our joint commitments to address and counter the world drug problem*. Vienna: UNODC. Available online at: <https://undocs.org/E/CN.7/2019/L.11>
- 4 UNODC (2014) *Joint Ministerial Statement. 2014 high-level review by the Commission on Narcotic Drugs of the implementation by member states of the political declaration and plan of action on international cooperation towards an integrated and balanced strategy to counter the world drug problem*. Vienna: UNODC. <https://www.drugsandalcohol.ie/24407/>
- 5 UNODC (2016) *Outcome document of the 2016 United Nations General Assembly Special Session on the world drug problem: our joint commitment to effectively addressing and countering the world drug problem*. Vienna: UNODC. Available online at: <https://www.unodc.org/documents/postungass2016/outcome/V1603301-E.pdf>

Commission on Narcotic Drugs

continued

- 6 International Drug Policy Consortium (IDPC) (2019) *The 'Vienna consensus' stifles progress on UN drug policy: Statement from the International Drug Policy Consortium*. London: IDPC.

Available online at:

http://files.server.idpc.net/library/Public-IDPC-statement_FINAL.pdf

- 7 Eurasian Harm Reduction Association (EHRA) (2019) *Not learned lessons: 10 more years to be left behind*. Vilnius: EHRA. Available online at: <https://harmreductioneurasia.org/not-learned-lessons-10-more-years-to-be-left-behind/>

International guidelines on human rights and drug policy

The United Nations Development Programme (UNDP); the Joint United Nations Programme on HIV/AIDS (UNAIDS); the World Health Organization; and the International Centre on Human Rights and Drug Policy have collaborated with international experts to produce *International guidelines on human rights and drug policy*.¹ The outputs of this collaboration were launched to coincide with the 62nd session of the Commission on Narcotic Drugs (CND) in March 2019 – they include a written set of guidelines and an online resource.²

Context

Human rights increasingly feature within international drug policy outputs. For example, every major UN political declaration on drug control since the late 1990s has reaffirmed the UN General Assembly resolutions' acknowledgement that 'countering the world drug problem' must be carried out 'in full conformity' with 'all human rights and fundamental freedoms'.³ However, while their importance has been recognised in writing, this has not always been reflected in practice internationally. The authors argue that one of the barriers to adopting a more human rights-based approach is a lack of clarity as to what human rights law requires of states in the context of drug control law, policy, and practice. The guidelines set out to address that gap.

Guidelines

The guidelines do not create new rights but highlight what states should and should not do to develop human-rights-compliant drug policies – meeting their human rights obligations, while also complying with their obligations under the various international drug control conventions.⁴ They are grounded in the international evidence base and aim to guide stakeholders involved in policymaking across the spectrum of related activities from cultivation to consumption. In doing so, the document covers a range of policy areas, from development to criminal justice to public health. It is important to note that this is not a toolkit for how to do drug policy, instead the guidelines are described as a 'reference tool' for stakeholders who are working at local, national, and international levels to ensure human rights compliance.

The guidelines are structured around five sections, as laid out in their introduction (pp. 4–5):

Section I presents general cross-cutting, or 'foundational', human rights principles underpinning the Guidelines, which may be seen as applicable irrespective of the issue or specific right in question.

Section II sets out universal human rights standards in the context of drug policy, taking the rights in question as its starting point. The section includes a brief overview of each human rights standard and its relation to drug policy before identifying consequent State obligations and recommended measures for human rights compliance. It should be noted that the order of this section does not imply any hierarchy of rights. It begins with the right to health to reflect the health goal of the international drug control system.

Section III addresses human rights concerns arising out of drug policy as it affects a number of specific groups: children, women, persons deprived of their liberty, and indigenous peoples. These, of course, are not the only groups with specific human rights needs or concerns of relevance to drug policy. They are emphasised as a consequence of more developed law concerning their specific human rights in relation to drug policy. Many others also experience disproportionate harm, inequities, and intersecting forms of discrimination on grounds of race, ethnicity, nationality, migration status, disability, gender identity, sexual orientation, economic status, and the nature and location of livelihood, including employment as rural workers or sex workers. The universal rights described in these Guidelines apply equally to these individuals and groups.

Sections IV and V conclude by outlining general matters related to the implementation of human rights obligations and relevant principles of treaty interpretation.

The Guidelines have been designed to place human rights at the forefront. However, many readers may approach the Guidelines with a focus on a specific drug policy topic or theme, or may be unfamiliar with specific rights. To assist with navigating the Guidelines, Annex I provides three thematic reference guides for development, criminal justice, and health. Each thematic guide brings together the most relevant guidelines for each of these issue areas.

An interactive website is also available to stakeholders. It contains extensive commentaries and references that complement the guidelines document. Stakeholders can search by specific rights, drug control themes, and other keywords, as well as follow links to source material.²

Lucy Dillon

1 United Nations Development Programme (UNDP) (2019) *International guidelines on human rights and drug policy*. New York: UNDP. <https://www.drugsandalcohol.ie/30447/>

2 For the guidelines and online resource, visit: <https://www.humanrights-drugpolicy.org/>

Human rights and drug policy

continued

3 See, for example, the UN General Assembly, *Resolution 73/192: International cooperation to address and counter the world drug problem*, UN Doc. A/RES/73/192 (2019). Available online at:

https://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/73/192

4 Single Convention on Narcotic Drugs (as amended by the 1972 Protocol) 520 UNTS 7515 (1961); Convention on Psychotropic Substances, 1019 UNTS 14956 (1971); Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1582 UNTS 95 (1988). Available online at: <https://treaties.un.org/>

UNAIDS report on health, rights and drugs

A Joint United Nations Programme on HIV/AIDS (UNAIDS) report, *Health, rights and drugs: harm reduction, decriminalization and zero discrimination for people who use drugs*, was published in March 2019.¹ It recommends implementing evidence-informed approaches to drug policy that are grounded in human rights and which would reduce the spread of HIV and other diseases through injecting drug use. These include harm reduction services and the decriminalisation of the possession of drugs for personal use. The report was published in advance of the ministerial segment of the 62nd Commission on Narcotic Drugs (CND) session and its authors advocated that its recommendations be used to inform that process.²

UNAIDS

UNAIDS was established in 1996 and describes itself as 'leading the global effort to end AIDS as a public health threat by 2030 as part of the Sustainable Development Goals'.³ It is at the core of the design, delivery, and monitoring of the global AIDS response, including shaping public policy on HIV. As part of its work, it leads on global data collection on HIV epidemiology, programme coverage, and finance. As a structure, UNAIDS is different from other elements of the UN system in that it is the only co-sponsored joint programme – it draws on the experience and expertise of 11 UN system co-sponsors, including the United Nations Office on Drugs and Crime (UNODC). It is also the only UN entity with civil society represented on its governing body. This more inclusive structure appears to contribute to UNAIDS' position as an advocate for a human rights and public health led approach to drug policy.

Health, rights and drugs

Health, rights and drugs shows that people who use drugs are being left behind when it comes to ongoing HIV infection. Despite a 25% decline in the incidence of HIV infections globally (all ages) between 2010 and 2017, HIV incidence is not declining among people who inject drugs. The report argues that this reflects a failure on the part of policymakers and lawmakers internationally to protect the health and human rights of drug users. Users continue to be unable to access interventions that have been evidenced to reduce the risk of infection – harm reduction interventions such as needle exchanges and opioid substitution therapy. In the foreword to the report, the executive director of UNAIDS, Michel Sidibé, describes this situation as 'unacceptable: people who use drugs have rights, and too often these rights are being denied' (p. 1).

The report has four substantive chapters. The first presents the current global situation in which drug users tend to be

criminalised and are heavily stigmatised. This contributes to a situation in which they are more vulnerable than other members of the population to drug-related infectious diseases; experience heightened levels of violence; and have higher rates of mortality. The second chapter argues that harm reduction is the foundation of a rights-based public health approach, and shows how it has consistently been found to reduce morbidity and mortality among people who use drugs.

Chapter 3 highlights the contradiction in current international drug policy. It is noted that the dominant approach continues to be one of criminalisation 'despite countries agreeing again and again ... that drug policy must be informed by human rights and committing to adopting a more balanced, integrated, evidence-informed and human rights-based approach' (p. 33). The fourth chapter explores the role of civil society in promoting rights and health-based approaches to drug use, bringing about changes in attitudes and policies, and delivering harm reduction services.

Conclusion

The authors conclude that by taking an approach characterised by criminalisation and law enforcement, the global drug framework has failed to achieve the global target to 'eliminate or reduce significantly and measurably' (p. 45) the supply and demand for illicit drugs by 2019. Instead, the situation has worsened. They argue for comprehensive harm reduction services and the decriminalisation of drug use and possession for personal use (see Box 1).⁴

UNAIDS recommendations

In the report, UNAIDS outlines a set of recommendations⁴ for countries to adopt, which include:

- 1 Fully implementing comprehensive harm reduction and HIV services, including needle-syringe programmes, opioid substitution therapy, overdose management with naloxone, and safe consumption rooms.
- 2 Ensuring that all people who use drugs have access to prevention, testing, and life-saving treatment for HIV, tuberculosis, viral hepatitis, and sexually transmitted infections.
- 3 Decriminalising drug use and possession for personal use. Where drugs remain illegal, countries should adapt and reform laws to ensure that people who use drugs have access to justice, including legal services, and do not face punitive or coercive sanctions for personal use.
- 4 Taking action to eliminate all forms of stigma and discrimination experienced by people who use drugs.
- 5 Supporting the full engagement of civil society as a source of information and to provide community-led services, mobilisation, and advocacy, especially in places where repressive policies and practices are the norm.
- 6 Investing in human rights programmes and health services, including a comprehensive package of harm reduction and HIV services, community-led responses, and social enablers.

UNAIDS report on health, rights and drugs continued

Lucy Dillon

- 1 Joint United Nations Programme on HIV/AIDS (UNAIDS) (2019) *Health, rights and drugs: harm reduction, decriminalization and zero discrimination for people who use drugs*. Geneva: UNAIDS. <https://www.drugsandalcohol.ie/30409/>

- 2 See accompanying article of this *Drugnet* issue: Dillon L (2019) Ministerial segment of 62nd session of Commission on Narcotic Drugs. *Drugnet Ireland*, 70: 5–6.
- 3 UNAIDS (2018) *About UNAIDS: Saving lives, leaving no one behind*. Geneva: UNAIDS. Available online at: <http://www.unaids.org/en/whoweare/about>
- 4 UNAIDS (2019) *Press release: Promises to improve health outcomes for people who inject drugs remain unfulfilled as 99% do not have adequate access to harm reduction services*. Geneva: UNAIDS. Available online at: http://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2019/march/20190313_drugs_report

European drug trends, 2019

The European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) published the *European drug report 2019: trends and developments*¹ on 6 June 2019. This report provides a snapshot of the latest drug trends across the 28 European Union (EU) member states, Norway and Turkey. The Health Research Board (HRB) provides the Irish data.

Europe is seeing signs of an increase in cocaine availability, with seizures at record levels. The report shows that in the EU 28, Norway and Turkey over one million seizures of illicit drugs are reported annually, around 96 million adults aged 15–64 years have tried an illicit drug in their lifetime, and 1.2 million people receive treatment each year for illicit drug use. In 2018, some 55 new psychoactive substances (NPS) were detected in Europe for the first time, bringing the total monitored by the EMCDDA to 730.

Commenting on the report, the Minister of State with responsibility for the National Drugs Strategy, Catherine Byrne TD, said:

The drug problem across Europe and here at home is of great concern, and the growing problem of cocaine use is particularly worrying. In response, the HSE has developed a campaign to raise awareness of the dangers associated with cocaine and crack cocaine use. I have also recently allocated funding for the development of strategic health initiatives by the HSE and Drug and Alcohol Task Forces around the country, and it is anticipated they will include projects to tackle cocaine use.

The report also highlights the issue of drug poisonings. Any death from drug use is a tragedy and we must continue to promote harm reduction and prevent overdose. Across Europe, Supervised Injecting Facilities have been instrumental in reducing drug-related harm and I remain firmly committed to the establishment of a pilot facility in Dublin city. I also welcome the increase in the provision of Naloxone and training in its delivery as another public health measure which can greatly reduce overdose deaths in Ireland.²

Cocaine seizures, distribution and health issues

Cocaine seizures are at the highest level for many years and the drug is becoming increasingly available. Around 73,000 people entered treatment for cocaine-related problems in 2017, with worrying numbers involved in crack cocaine use, which is evident in Ireland as well. The price of cocaine has not increased but in 2017 the purity of the drugs at street level reached the highest it had been for a decade. While large-volume trafficking is still a major challenge for law enforcement agencies, there is increasing evidence that distributors are taking advantage of the opportunity presented by social media, the darknet, and other technological advances.

Heroin is still the most common illicit opioid on the drug market in Europe and is a major contributor to health and social costs. Seizures of heroin and of acetic anhydride, a precursor chemical, have increased as have discoveries of heroin-processing laboratories. The synthetic opioids that have driven the opioid epidemic in North America only represent a small share of the European drug market but they are a growing concern with links to overdoses and death. Six fentanyl derivatives were detected in Europe for the first time in 2018. Drug treatment monitoring data indicate that one in every five clients entering treatment for opioid use now reports a synthetic opioid as their main problem drug.

Cannabis remains the most widely used illicit drug in Europe. Some 17.5 million or 14.4% of young Europeans (15–34 years) are estimated to have used cannabis in the last year (EU–28). Around 1% of adults (15–64 years) in the EU are estimated to be daily, or almost daily, cannabis users. Cannabis is now the substance most often named by new entrants to drug treatment as their main reason for contact.

Synthetic drug production in Europe appears to be growing, diversifying, and becoming more innovative. Europe is producing amphetamines and MDMA for use in Europe and globally. The purity of both types of drugs is as high as it has been for several years and there are indications of increasing levels of production, such as raids on MDMA laboratories and detections of precursor dumping.

The situation described in the *European drug report* is presented below under a series of headings. The EMCDDA used the most recent data available to provide aggregate figures. While data on some indicators, such as treatment demand, are supplied annually, the year of the most recent prevalence data can vary.

European drug trends, 2019

continued

Cocaine

European situation

- Around 2.6 million young adults (15–34 years) have used cocaine in the last year across Europe. Of the 12 countries that have reported prevalence figures since 2016, three have reported higher estimates and nine countries were stable compared with the previous survey.
- Between 2014 and 2017, there was a 35% increase in the number of first-time entrants to drug treatment services with cocaine as a main problem drug.
- An estimated 10,600 clients entered treatment for primary crack cocaine use in 2016. Many of these clients report heroin as a secondary problem drug and they tend to be more socially marginalised than those in treatment for the use of powder cocaine.
- Analyses of municipal wastewater demonstrated an increase in cocaine residues in 22 cities (out of a total of 38) between 2017 and 2018.

Cannabis: availability and use

- Cannabis is the most commonly used illicit drug in Europe, across all age groups.
- The EMCDDA estimates that 14.4% of young adults (15–34 years) – an estimated 17.5 million people – used cannabis in the last year. Last-year prevalence in this age group ranged from 3.5% in Hungary to 21.8% in France.
- Cannabis is responsible for the greatest share of new entrants to treatment. The overall number of people entering treatment for the first time and who are seeking treatment for problem cannabis use increased by 67% between 2006 and 2017, although there was a small reverse between 2016 and 2017.
- In 2017, there were 782,000 seizures of cannabis products reported in the EU.

New psychoactive substances

- Data on NPS are based on notifications by member states to the EU Early Warning System (EWS). In 2018, some 55 new substances were reported for the first time (51 in 2017). By the end of 2018, the EMCDDA was monitoring more than 730 NPS, compared with around 300 monitored in 2013. The number of new substances being identified for the first time each year increased sharply between 2009, when 24 were identified, and 2014, when there were 101 notifications, but has since declined with 55 identified in 2018.

- 390 substances, approximately one-half of the new substances being monitored by the EU EWS, were detected in Europe in 2017.
- In 2017, almost 78,000 seizures of NPS were reported across Europe, 53,000 of which were in EU member states.
- Synthetic cannabinoids and cathinones were the most frequently seized NPS in 2017, with just over 32,000 seizures reported. In total, 118 synthetic cathinones have been identified since 2005, with 14 reported for the first time in 2016, a decrease from the 31 reported in 2014.
- Production of MDMA is concentrated in Belgium and the Netherlands and has increased in recent years as substitutes for controlled precursors of the drug have become more available.
- An estimated 6.6 million MDMA tablets were reported seized in 2017, the highest number reported in the EU in any year since 2007.
- The EMCDDA estimates that 2.1 million young adults (15–34 years), or 1.7% of this age group, used MDMA/ecstasy in the last year. National estimates vary considerably with the Netherlands highest at 7.1%.

Opioids (mainly heroin)

- There were an estimated 1.3 million high-risk opioid users in Europe in 2017.
- In 2017, use of opioids was reported as the main reason for entering specialised drug treatment by 177,000 clients or 37% of all those entering drug treatment in Europe. Of these, 32,000 were first-time entrants, a drop of 3,800 compared with the previous year. The number of first-time heroin clients more than halved from a peak in 2007, to a low point in 2013.
- It is estimated that at least 8,279 overdose deaths, mainly involving opioids, occurred in the EU in 2017. As in previous years, the United Kingdom (34%) and Germany (13%) together account for nearly one-half of the European total.

Brian Galvin

- 1 European Monitoring Centre for Drugs and Drug Addiction (2019) *European drug report 2019: trends and developments*. Luxembourg: Publications Office of the European Union. <https://www.drugsandalcohol.ie/30619/>
- 2 Health Research Board (HRB) (2019) *HRB compares Irish drug situation with the rest of Europe*. Dublin: HRB. <https://www.hrb.ie/news/press-releases/single-press-release/article/hrb-compares-irish-drug-situation-with-the-rest-of-europe/>



At the launch of the *European drug report 2019* in June, European Commissioner for Migration, Home Affairs and Citizenship, Dimitris Avramopoulos, and EMCDDA Director Alexis Goosdeel (left)

Alcohol industry involvement in policymaking: a systematic review

Research indicates that the most effective alcohol policies are those that regulate the actions of the alcohol industry, including reducing the affordability of alcohol and decreasing its availability.¹ However, national alcohol policies have tended to favour policies that allow the alcohol industry scope for self-regulation and promote non-regulatory measures. This may reflect the influence of the alcohol industry in defining the scope and content of alcohol policy debate. A recent systematic review² published in the journal *Addiction* investigated the role of the alcohol industry in policymaking and the ways in which the industry attempts to influence this process.

Methods

The authors searched for peer-reviewed studies published between 1980 and 2016. A total of 15 unique studies published in 20 articles were included in the review. The majority of these studies were carried out in high-income, English-speaking countries, including the United Kingdom, the United States, Australia, and New Zealand. The remaining studies were carried out in Africa, Thailand, Hong Kong, and Poland. The studies were primarily qualitative and a thematic approach was used to synthesise the findings.

Main findings

The authors found that the alcohol industry had a 'pervasive influence' on policymaking across all countries and all policy contexts. They identified two ways in which the alcohol industry sought to influence policy. The first was framing the policy debates in a clear and convincing manner that was protective of commercial interests. The second was influencing policy activities to manage potential threats to industry interests through the use of short-term and long-term lobbying strategies.

1. Framing the debate

Strategically, alcohol industry actors placed themselves as key partners to the government in developing and implementing alcohol policy. This legitimised their position at the table, giving them scope to shape the content and nature of the policy debate. They used this position to steer policy discussion away from policies that would restrict the industry's ability to price, advertise, and brand their products.

Industry actors attempted to shift the responsibility of alcohol consumption and related harms away from alcohol and the alcohol industry and towards the individual consumer. This allowed them to advocate for a policy response that would target a minority of heavy alcohol users. Industry actors were found to advocate for 'partnership' approaches, such as industry-led education and targeting smaller subpopulations of high-risk drinkers. The authors reported that industry actors were found to use misleading claims about the effectiveness of their proposed interventions and to question the unintended consequences of population-based strategies as well as its evidence base. In this way, alcohol industry actors can be seen to be making strong rhetorical commitments to evidence-based policy while protecting their own commercial interests.

2. Influencing activities

Across all of the studies, alcohol industry representatives sought to be involved in every aspect of the policymaking process, including public consultations, parliamentary committees, and working groups. They engaged in both short-term and long-term lobbying tactics. Long-term lobbying strategies included sustained efforts to build close and lasting relationships with key policymakers through frequent contact and other forms of engagement. This normalises the involvement of industry actors in policy processes, helps keep any issues that would be contrary to commercial interests off policy agenda, and provides a basis for reactive lobbying in response to specific policy debates or issues that may arise. Alcohol industry actors were also found to use third parties from outside the industry to engage policymakers. This includes funding think tanks or academics to carry out or disseminate policy-relevant research with supportive findings, creating a separate body of literature that could be referenced to support their policy positions.

Conclusions

This systematic review demonstrates that alcohol industry actors are strategically involved in policymaking to advance their own commercial interests. The authors note that industry actors can make 'intuitively plausible, and highly nuanced, arguments that can appear compelling if they are allowed to go unchallenged' (p. 1574).²

Claire O'Dwyer

- 1 Babor TF, Caetano R, Casswell S, Edwards G, Giesbrecht N, Graham K, et al. (2010) *Alcohol: no ordinary commodity – research and public policy*. Oxford: Oxford University Press.
- 2 McCambridge J, Mialon M and Hawkins B (2018) Alcohol industry involvement in policymaking: a systematic review. *Addiction*, 113(9): 1571–84. <https://www.drugsandalcohol.ie/30180/>

PREVALENCE AND CURRENT SITUATION

Community experiences of serious organised crime in Scotland

In June 2018, a report that examined community experiences of serious organised crime (SOC) in Scotland was published by the Scottish Government.¹ The study aimed to examine three areas:

- Relationships that existed between SOC and communities in Scotland
- Experiences and perceptions of the scope and nature of SOC among residents, stakeholders, and organisations
- Impact of SOC on community wellbeing, and whether harms linked to SOC can be alleviated.

Methodology

This study drew on a qualitative approach and involved four stages. Overall, data were collected from 188 participants.

Stage 1: Site selection

The site selection was based on community experiences of organised crime, interviews with key stakeholders (e.g. police, statutory and voluntary agencies), police intelligence, and analyses by the Scottish Community Development Centre.

Stage 2: Case study fieldwork

Qualitative interviews, focus groups and observations were carried out between February and November 2017, with community participants and agencies using two research teams. This was to minimise harm and to ensure anonymity and confidentiality. The themes addressed in the interviews included perceptions of community; meanings associated with 'organised' crime; experiences of victimisation and/or crime; and changes over time (p. 19). A thematic interview template was utilised in interviews. Questions were modified according to respondents, experiences, and community. Young people (n=16) and teachers (n=2) from three secondary schools took part in focus groups (n=5). Table 1 shows the demographic profile of the community participants.

Table 1: Demographic profile of community participants

Field site	Male	Female	<18 yrs	18–30 yrs	31–50 yrs	51–75 yrs	Total
Site 1	10	14	2	4	13	5	24
Site 2	10	11	9	4	4	4	21
Site 3	10	14	5	3	10	6	24
Site 4*	3	12	0	4	10	1	15
Totals	33	51	16	15	37	16	84

Source: Frazer *et al.*, 2018, p. 20

* Site 4 involved fieldwork in two 'mini' case study sites.

Informal interviews and observations were carried out in local business premises (n=12). These interviews explored the advantages and disadvantages of doing business in these areas; security; victimisation; relationships; and perceptions of organised crime. To ensure anonymity, no demographic details were recorded. Interviews with key stakeholders (n=52) explored the nature and patterns of organised crime, changes over time, interventions, and success and failures (p. 20).

Stage 3: Triangulation

A data calibration exercise detected two gaps in the data collection. Hence, two more data-collections were carried out:

- 1 Interviews and focus groups were carried out with individuals with a lived experience of organised crime (n=12).
- 2 Interviews were carried out with community and statutory agencies who were engaged in crime of a more diffuse nature (n=14, p. 21).

Stage 4: Data analysis and community co-inquiry

Following data analysis, the findings were presented to a subsample of participants (n=33) at 'co-inquiry events' (p. 22). These events involved a two-stage process. Participants were first asked to discuss whether the findings were or were not in alignment with their experiences. Then they were asked to consider changes in practice, policy or community responses that could stop crime, address social determinants, and address the impact of crime in the community. The outcomes of this process informed final conclusions and recommendations.

Results

The main findings were categorised into four themes: community experiences; narratives; emergent and diffuse organised crime; and service delivery and community response.

Community experiences

Organised crime was identified as a prevailing and routine aspect of normal everyday living in local communities. It was believed that firms, families and 'faces' involved were 'local' (p. 3).² The most prominent crime visible was street crime, such as drug dealing and theft. However, it was acknowledged that most SOC crimes were not visible to the public. The main impact of SOC in Scotland was believed to be the result of the illicit drugs market, which results in harmful outcomes for users, their families, and community as a whole.

Community experiences of serious organised crime in Scotland continued

Narratives

A range of narratives emerged across case study sites relating to the push and pull factors that led to organised crime involvement, such as:

- Poverty and inequality
- Family, mentoring and recruitment
- Boredom and excitement
- 'Flash cars' and ready cash.

Emergent and diffuse organised crime

While it was evident that the nature, form, and extent of SOC today was similar to previous generations, there was evidence to suggest that new trends were emerging in relation to youth crime, drug distribution, and market diversification (p. 45). Advancements in technology played a part. For example, it was no longer vital to be part of a gang, recruitment could easily occur via social media as and when needed. Mobile flexible markets have become common in smaller locations where a SOC presence was not evident; they operated differently to those elsewhere. For example, mobile criminal actors were known to take over premises by taking advantage of people with vulnerabilities, such as age, addiction, or mental health (p. 48). Occasionally, these mobile networks worked with local crime groups and were known to collaborate on other criminal offences (p. 49). The ability for SOC offenders to set up legitimate businesses in order to launder and invest money was viewed as a real threat to the community. No links were shown between organised crime groups and migrant communities; however, similar to other vulnerable cohorts, there was some evidence to suggest that they were vulnerable to labour exploitation and human trafficking.

Service delivery and community response

The presence of SOC was considered a challenge for services and its delivery. By their very nature, extensive resources are required to address the problems that arise along with their associated effects on the community. In addition, other obstacles, such as stigma, fear and mistrust, existed between

communities and services as well as reduced responses by service providers to poverty and social exclusion. Existing levels of austerity further exacerbated these issues.

Conclusion and recommendations

Recommendations were put forward to address the four main themes that emerged in the course of the study:

- **Developing resilient communities:** The existing SOC strategy, framed by four strategic principles – Divert, Deter, Detect and Disrupt – should be extended to include an additional D – Develop, which should be aimed at addressing harms connected to organised crime.
- **Changing the narrative:** Narratives should be challenged at a national, community, and individual level.
- **Addressing vulnerability:** Strategies are required to prevent the exploitation of individuals that are vulnerable.
- **Broadening community partnership:** In order to develop cohesive interventions and responses, it is important that police, community, and statutory organisations work in partnership.

This is the first study to investigate community experiences of SOC in Scotland. It has extended knowledge and understanding of organised crime within Scottish communities in locations where SOC is embedded and where mobile forms of SOC are present. As acknowledged by the authors, 'only by shining a light on an issue that is often in the shadows, or is disordered through the glare of media glamourisation and dubious forms of celebrity, can real and effective responses be formulated' (p. 79).

Ciara H Guiney

- 1 Fraser A, Hamilton-Smith N, Clark A, Atkinson C, Graham W, McBride M, et al. (2018) *Community experiences of serious organised crime in Scotland: research report*. Edinburgh: Scottish Government. Available online at: <https://www.gov.scot/publications/community-experiences-serious-organised-crime-scotland/>
- 2 Scottish Government (2018) *Community experiences of serious organised crime in Scotland: research findings*. Edinburgh: Scottish Government. Available online at: <https://www.gov.scot/publications/community-experiences-serious-organised-crime-scotland-research-findings/>

The drug economy and youth interventions

The launch of *The drug economy and youth interventions: an exploratory research project on working with young people involved in the illegal drugs trade* was held on 30 April 2019.¹ The study was carried out by Dr Matt Bowden of the Technological University Dublin and is published by CityWide Drugs Crisis Campaign. As well as a presentation on the report's key findings, the launch included:

- The findings of research into the views and experiences of drug dealers by Dr Fiona O'Reilly
- The experiences of those delivering interventions with young people affected by the 'drug economy':
 - Angela Birch of the Ballymun Regional Youth Resource discussing the Easy Street project
 - Karl Ducque and Gary Lawlor of the Targeted Response to Youth (TRY) intervention
- A closing statement by John Loneragan, former governor of Mountjoy Prison, Dublin.

Drug economy and youth interventions

The drug economy and youth interventions report stems from a 2016 study on drug-related intimidation that identified a need to explore the issue of early intervention with young people involved in drug distribution in Ireland.² The report presents the

The drug economy and youth interventions continued

findings of an exploratory study based on a review of the Irish and international literature on violence and intimidation in the illegal drug trade and in-depth qualitative interviews with seven practitioners working in the Dublin area.

Literature review

The literature review depicts an environment in which Irish drug markets have become more complex over the last couple of decades. There are a number of reasons given for this growing complexity, including the changing profile of drug use to polydrug use; the open nature of dealing and use in public places; the debt-based nature of distribution; and a greater association of the market with violence and intimidation. A working definition of intimidation cited in the report 'is "a serious, insidious and coercive behaviour intended to force compliance of another person against their will" ... involving verbal threats or actual physical violence' (p. 10).

Experiences of working with young people

The main body of the report presents the findings of the qualitative work. Those interviewed had all worked with young people and families in the community who had experienced drug-related problems, were involved in some form of drug selling or holding, and had experienced some associated violence or threat of violence. They varied in their level of experience (from seven to 35 years of working in the field) and were based in different kinds of projects – youth work, drug teams, social work, and youth diversion. Their narratives explored the context in which they were delivering their services, the nature of the problem faced by young people with whom they worked, and possible ways of addressing these challenges.

Key findings

Key findings are outlined below.

Nature of the problem

- The drug economy provides opportunities for young people to access work; the structure of drug distribution networks provides a range of roles from various levels of dealers to those who 'hold' or 'carry' drugs. Working within this economic structure enables young people to access cash and consumer goods. This, it was argued, provides a more attractive alternative to 'precarious' labour in, for example, the service industry: 'Drug selling is regarded as an alternative to labour market participation: seen as a type of entrepreneurship in an unregulated economy' (p. 17). Economic terms were often used by participants when describing the system of distribution – labour force participation, qualifications, skills, etc.
- Drug distribution is based on a financial system of credit or 'fronting' – recouping of debts operates under the threat of violence. Drug-related intimidation and drug debt intimidation are described as central to how these distribution networks are structured and feed into an environment where 'dominant drug dealers appear to rule within communities' (p. 30).
- In an environment where drug use was described as 'normalised' and distribution structured around peer-

to-peer networks, initiation into the drug economy was found to go unrecognised at times. The term 'grooming' was used by some participants to describe the process whereby a young person starts to do favours for those involved in distribution in return for small amounts of cash. As they show they can be trusted, they can then progress to holding money, drugs or weapons. While this is sometimes in exchange for cash, movement into these more involved roles in the distribution network can be required as a way of paying a drug debt.

- While intimidation was predominantly a male experience, females were far from immune. The author identifies a particular concern about young women being asked to engage in sexual activity to expunge debts.

How to tackle the problem

- Based on the participants' experiences of working with young people in the community, a gap was identified in current drug education and prevention practice. It was suggested that there should be an increased focus on educating young people about the nature of the drug economy and how it uses credit and debt as an economic bond that often leads to intimidation and violence. This was key where drug distribution is peer-to-peer – young people need to understand that drugs are not free, by accepting them without immediate payment, they are entering an economic bond that will require payment of some kind.
- A recurring theme was that young people involved in drug distribution are not 'untouchable'. Service providers have found ways to engage with these young people and help them desist from their role in the drug economy. Central to this is the quality of the relationship that a worker has with the young person. Where this is based on a common understanding and respect, it is possible to have a positive impact on the young person's decision-making and to support a desistance process.
- In a context where the drug economy offers young people access to income, there was a call for access to 'real' or 'proper' educational and work pathways to be made available as an alternative.
- The report argues that young people who live in the areas where a drug economy exists need to have more of a voice in the narrative that defines their realities. The 'gangland' narrative predominates in the media, which is unhelpful when trying to find solutions to the problems being experienced by young people in these areas. It also contributes to the stigmatisation of young people from certain areas, irrespective of any involvement in the drug economy.
- There was a call for improved early intervention through child and family preventive services, as a way of addressing intergenerational poverty.
- For policing and criminal justice responses, participants identified a need for authorities to be able to target the assets of those involved in the drug economy using 'a model similar to the Criminal Assets Bureau, except working on a micro level' (p. 28); and to introduce some way of measuring social harm and applying it within the criminal justice responses.

Easy Street and Targeted Response to Youth

At the launch of the report, there were presentations from two projects that work to support young people involved in

The drug economy and youth interventions continued

or at risk of becoming involved in the drug economy – Easy Street project in Ballymun, Dublin³ (running since 2009) and the Targeted Response to Youth (TRY) on Donore Avenue, Dublin⁴ (first piloted in March 2017). The evidence-based approach taken in these projects is identified in the report as a suitable model for working with young people. Broadly speaking, both projects take an outreach and bridging approach, in which youth workers make contact at street level, build trust, and then act as a ‘connecting node’ or ‘host’ to enable young people to extend their social networks beyond those associated with the drugs economy and to build on positive traits. They work with individual young people and broader networks of young people in the community. They also support them in accessing education or work pathways, with the aim of either preventing them engaging in or desisting from the drug economy. While neither project has carried out an outcome study, both described positive experiences of working with young people within this model. Particular challenges they faced were in securing adequate funding to meet the level of demand for their work and having access to viable education and employment opportunities for their young people.

Concluding comment

There were three recurring themes throughout the presentations and the subsequent discussion. First, people

were conflicted about engaging with people who were involved in drug distribution in their communities. However, it was explained that doing so was about understanding their behaviour with the aim of prevention; it was not about excusing their behaviour. The second recurring theme for practitioners, including John Loneragan, former governor of Mountjoy Prison, was the need for any engagement to be structured around a strong relationship with an advocate, characterised by trust and understanding. Third was the message that young people involved in the drug economy or at risk of getting involved *were* reachable. If there were to be viable educational and employment pathways open to them, it was believed that many would desist from the drug economy.

Lucy Dillon

- 1 Bowden M (2019) *The drug economy and youth interventions: an exploratory research project on working with young people involved in the illegal drugs trade*. Dublin: CityWide Drugs Crisis Campaign. <https://www.drugsandalcohol.ie/30487/>
- 2 Connolly J and Buckley L (2016) *Demanding money with menace: drug-related intimidation and community violence in Ireland*. Dublin: Citywide Drugs Crisis Campaign. <https://www.drugsandalcohol.ie/25201/>
- 3 For further information on the Easy Street project, contact Angie Birch of Ballymun Regional Youth Reach Resource on angie.birch@bryr.ie and <http://www.bryr.ie/>
- 4 For further information on the TRY project, contact Fearghal Connolly, project coordinator, Donore Community Drug and Alcohol Team on fearghal@donorecdat.ie and <https://www.donorecdat.ie/>

Alcohol treatment figures from the NDTRS, 2011–2017

The National Drug Treatment Reporting System (NDTRS) is a national surveillance database on treatment for problem drug and alcohol use in Ireland. In March 2019, the NDTRS published its latest alcohol treatment figures, which cover the seven-year period 2011–2017. Over this period, 55,675 cases were treated for alcohol as a main problem.¹

Key findings

The number of cases decreased to 7,350 in 2017 from a high of 8,876 in 2011. The proportion of new cases treated (those never before treated for problem alcohol use) decreased from 52.3% in 2011 to 47.6% in 2017 (see Table 1). The proportion of previously treated cases increased over the reporting period from 46.3% in 2011 to 49.7% in 2017.

It is important to note that each case in the NDTRS database relates to a treatment episode and not to a person. This means that the same person may be counted more than once in the same calendar year, if that person had more than one treatment episode in that year.

Table 1: No. of cases with alcohol as a main problem by treatment status, NDTRS 2011–2017

	2011		2012		2013		2014		2015		2016		2017	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Total	8876		8609		7819		7760		7618		7643		7350	
New cases	4645	52.3	4149	48.2	3708	47.4	3772	48.6	3553	46.6	3678	48.1	3500	47.6
Previously treated	4110	46.3	4353	50.6	3932	50.3	3807	49.1	3948	51.8	3783	49.5	3652	49.7
Treatment status unknown	121	1.4	107	1.2	179	2.3	181	2.3	117	1.5	182	2.4	198	2.7

Alcohol treatment figures from the NDTRS, 2011–2017 continued

Table 2: No. of treated cases with alcohol as a main problem, by type of service provider, NDTRS 2011–2017

	2011		2012		2013		2014		2015		2016		2017	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Total	8876		8609		7819		7760		7618		7643		7350	
Outpatient	4635	52.2	4510	52.4	4221	54.0	4133	53.3	4018	52.7	4005	52.4	3894	53.0
Inpatient*	3378	38.1	3309	38.4	2809	35.9	2803	36.1	2916	38.3	2994	39.2	2949	40.1
Low threshold†	591	6.7	519	6.0	521	6.7	605	7.8	480	6.3	495	6.5	436	5.9
Prison	272	3.1	271	3.1	268	3.4	219	2.8	204	2.7	149	1.9	71	1.0

* Includes any service where the client stays overnight, e.g. inpatient detoxification, therapeutic communities, respite and step-down.

† Low-threshold treatment programmes are harm reduction centres targeted at drug users.

Case characteristics

In 2017, as in previous years, over one-half (53%) of cases were treated in outpatient facilities (see Table 2). In addition, 4 in 10 cases (40.1%) were treated in residential settings, again similar to previous years.

The most recent data (i.e. 2017) show that the median age to start drinking for cases in treatment for problem alcohol use was 16 years, a trend that has remained steady over the seven-year reporting period. Over this period, the proportion of cases classified as dependent increased from 58.8% in 2011 to 72% in 2017. Dependent means that a person feels that they are unable to function without alcohol and the consumption of alcohol becomes an important – or sometimes the most important – factor in their life.² A significant finding of the analysis was that in 2017 approximately two-thirds (66.8%) of new cases were classified as alcohol dependent. According to Dr Suzi Lyons, senior researcher at the Health Research Board, this means that ‘more people are presenting when the problem is already severe which makes treatment more complex and recovery more difficult’.

The median age of treated cases increased over the seven-year period from 38 years in 2011 to 41 years in 2017. The median age of new cases also continued to rise from 36 years in 2011 to 40 years in 2017.

In 2017, over one-half (52.1%) of cases were unemployed, while the proportion of cases recorded as homeless increased from 6.2% in 2011 to 8.4% in 2017. Also, in 2017, 1.6% of cases identified as Irish Traveller; this compares with 0.7% of the general population in the latest census (Census 2016).³

One in five cases treated for problem alcohol use reported problem use of more than one substance (polydrug use) in 2017. Cannabis (60.5%) was the most common additional drug reported in 2017, followed by cocaine (41.8%) and then benzodiazepines (22.9%). Cocaine increased from 28.8% in 2011 to 41.8% in 2017.

Case gender, 2017

The majority of cases in 2017 were male (64.9%), similar to previous years. The median age of treated cases for females (43 years) is higher than for males (40 years). This is further reflected in the median age for new cases entering treatment (38 years for males vs 43 years for females). Females also account for a higher proportion of cases in treatment aged 50 years or over (31.6%) than males aged 50 years or over (25%). Homelessness was more prevalent among males (10.1%) than females (5.4%).

In 2017, 74.2% of males were classified as alcohol dependent, as compared with 68.1% of females.

The proportion of cases with an additional other problem drug was higher for males (29.3%) than for females (16.6%). The four most common additional drugs (cannabis, cocaine, benzodiazepines, and opiates) for cases in alcohol treatment are the same for both males and females. There are, however, differences in the proportion reporting use of these drugs based on gender.

The findings of this bulletin can be used to inform research, policy, and practice in the area of alcohol addiction and treatment in Ireland.

Derek O’Neill

- 1 Health Research Board (2019) *National Drug Treatment Reporting System 2011–2017 alcohol data*. Dublin: Health Research Board. <https://www.drugsandalcohol.ie/30202>
- 2 Health Service Executive (HSE) alcohol misuse definitions. For further information, visit: <https://www.hse.ie/eng/health/az/a/alcohol-misuse/defining-a-drink-problem.html>
- 3 Data on ethnicity is taken from Census 2016 from the Central Statistics Office (CSO). For further information, visit: <https://www.cso.ie/en/releasesandpublications/ep/p-cp8iter/p8iter/p8e/>

Experience of the treatment demand indicator in Europe

The treatment demand indicator (TDI) is an epidemiological indicator, used in the European Union (EU), with the aim of providing a common format on collection and reporting of data on people seeking treatment for problem drug use. A recent study reviewed the implementation of the TDI and the data analysis and trends it has provided.¹

The TDI is one of five key epidemiological indicators of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). The TDI provides a common format that is used to collect specific information on the number, characteristics, and substance use patterns of drug users entering treatment in European countries. The information collected can provide data on general trends in problem drug use and treatment uptake and patterns. The information that is collected through the TDI is used to inform the yearly *European Drug Report and the Statistical Bulletin*. TDI data from Ireland are provided from the National Drug Treatment Reporting System to the EMCDDA, with the most recent data published in April 2019.²

Treatment data tend to be the primary source of information on the drug user population at national level, providing a substantial sample of the entire population with drug problems, making it a highly valuable data collection tool. Data are used to analyse the availability and accessibility of treatment services, providing important information for evaluation and planning of treatment services.

As the TDI collects standardised information, it enables analysis and comparisons to be made in treated problem drug use across European countries. The EMCDDA is responsible for the collection of data using the TDI and it coordinates this data collection through 30 national monitoring centres. In 2012, the TDI underwent a revision, whereby the current protocol used is TDI Protocol 3.0.³

This review looked at the information collected through the TDI over the last 10 years and its implementation.

Key findings

Some of the most recent findings (for 2015 or the most recent year available) show that in 2015 some 29 EU countries reported data on 457,811 clients entering drug treatment from 6,846 drug treatment centres. Of these, 37% were first-time entrants to treatment; 80% of first-time treatment entrants were male, with a mean age of 33 years. Some 37% of the clients were unemployed (compared with 9.4% in the general population), 7% were homeless and/or without stable accommodation. In 2015, across Europe, opioids, mainly heroin, accounted for 38% of the clients, followed by cannabis at 31% and cocaine at 13%.

Trend analysis for the last 10 years has shown the changing pattern of drug use. Data for trend analysis in Europe are only available since 2006. In the period 2006–2015, the number of countries reporting TDI data rose from 27 to 29, and the number of clients increased from 396,349 to 467,811.

First-time treatment entrants between 2006 and 2015 reporting the primary drug problem as opioids decreased from 56,000 (37%) to 33,000 (21%). In most European countries, the number of first-time treatment entrants for primary cannabis use has consistently increased from about 43,000 (28% of all new drug clients) in 2006 to about 75,000 (47% of all new drug clients). Trend analysis is carried out for all reporting countries; however, significant differences to the general analysis can exist between individual countries. These country differences should be considered when reporting on European drug treatment demand data.

TDI data limitations

While the TDI provides important data and is a highly valuable tool, some of its data limitations should be considered. The TDI represents only a certain part of the drug treatment system, and this representation can vary significantly across the different countries. How data are collected can differ between countries and there can be fluctuations in data reporting due to the number and type of treatment centres reporting as well as the number of clients. Double counting also exists within the data, where individuals are registered more than once in the database, leading to an overestimation of the number of individuals in treatment. Another TDI limitation to consider is the restricted range of substances included in the data collection. Data are only collected on illicit drugs, no data on tobacco are collected, and information is only collected on alcohol if it is reported as a secondary drug for entering treatment.

However, the TDI is the largest drug-related dataset in Europe, and is extremely useful for policymakers at European level. The common data collection tool enables drug treatment professionals to compare their national treatment data against other countries to try to improve national responses. It is an extremely important source of information providing evidence on the extent and patterns of drug use and treatment service utilisation across the EU, Norway, and Turkey.

Helen Kennelly

- 1 Montanari L, Pirona A, Guarita B, Hedrich D and Mounteney J (2019) The experience of the treatment demand indicator in Europe: a common monitoring tool across 30 countries. *J Stud Alcohol Drugs*, Suppl s18: 139–51. <https://www.drugsandalcohol.ie/30226/>
- 2 Health Research Board (2019) *National Drug Treatment Reporting System 2011–2017 drug data*. Dublin: Health Research Board. <https://www.drugsandalcohol.ie/30197/> and <https://www.hrb.ie/publications>
- 3 European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2012) *Treatment demand indicator (TDI) Standard protocol 3.0: guidelines for reporting data on people entering drug treatment in European countries*. Luxembourg: Publications Office of the European Union. <https://www.drugsandalcohol.ie/18436/>

Experiences of people engaged in long-term methadone maintenance treatment

On 10 December 2018, the Dún Laoghaire Rathdown Drug and Alcohol Task Force (DLRDATF) launched their report, *'Just maintaining the status quo'? The experiences of long-term participants in methadone maintenance treatment*.¹ The report documents the findings of a qualitative study examining the experiences of people engaged in long-term methadone maintenance treatment in the Dún Laoghaire Rathdown area of South Dublin.

This is the first Irish study to specifically examine the experiences of individuals who are engaged in long-term methadone maintenance treatment. The study was conducted by a team of researchers from Trinity College Dublin, led by Dr Paula Mayock of the School of Social Work and Social Policy. The main study objective was to examine the lived experiences of people receiving methadone treatment, their social relationships, health, and social care needs.

The study examined the experiences and perspectives of 25 people (16 male, 9 female) who first accessed methadone treatment a minimum of 10 years ago, and who reported at least one episode of opioid substitution treatment since first accessing treatment. Study participants were recruited through services located in the Dún Laoghaire Rathdown area, including specialist addiction clinics, community and voluntary addiction services, primary care services, and supported temporary accommodation services. Interviews were conducted between August 2017 and February 2018.

The average age of research participants was 43 years. Almost one-third (32%) of participants were aged 35–39 years; 56% were aged 10–49 years; and the remaining 12% were aged 50 years or older. Almost two-thirds of participants (64%) had first accessed methadone maintenance treatment more than 20 years previously.

Key findings

- The majority of participants reported that methadone maintenance treatment had positively impacted at least one aspect of their lives. The most commonly reported benefit was stability and normality, with improved capacity to fulfil roles as parents, family members, and friends.
- The average age of first drug use was 14 years of age, while the average age of first heroin use was 19 years of age.
- Levels of educational attainment were low among participants, with one in four (24%) having no educational qualifications and more than one-half (52%) not progressing beyond Junior Certificate level.

- Almost one-third of participants (32%) were homeless or living in unstable accommodation at the time of interview. More than one-half of the study participants (56%) had experienced homelessness at some point in their lives.
- Mental health problems, including depression, were widely reported among study participants.
- Many reported having chronic illnesses, including hepatitis C, liver cirrhosis, and a range of respiratory, renal, and coronary diseases.
- Negative experiences were reported by many, including negative interactions with treatment services and health professionals, and little autonomy in their treatment progression, particularly in relation to long-term rehabilitation planning.
- Stigma was a dominant experience reported by study participants. Stigma was reported on many levels, including within treatment settings and within the communities where people resided. Participants reported feeling stereotyped and disrespected within their treatment setting, and many reported attempting to conceal their methadone use and clinic attendance from family and friends. Other forms of stigma related to being an older person in treatment and fear of judgement or rejection due to continued engagement in treatment.
- Participants perceived themselves as stigmatised health-service users, with many feeling excluded from employment and having little prospect of further education.
- Levels of social reintegration among participants were reported as extremely low. The majority reported being unemployed with no realistic prospect of employment.
- Most participants did not have access to the economic, social or personal resources needed to support and sustain recovery.

Conclusions

The report shows the complexity and characteristics of people who are long-term participants in methadone maintenance treatment. The authors highlight issues experienced by this group, including physical and mental health problems, isolation, social exclusion, and loneliness. The authors note that age combined with long-term drug use and treatment careers indicate that this group have many challenging health, social, and economic needs. The report also highlights that although methadone treatment had a positive impact on the lives of the study participants, multifaceted and multidisciplinary supports, including education, training, housing and family welfare, are needed in order to achieve social reintegration.

Anne Marie Carew

1 Mayock P, Butler S and Hoey D (2018) *'Just maintaining the status quo'? The experiences of long-term participants in methadone maintenance treatment*. Dublin: Dún Laoghaire Rathdown Drug and Alcohol Task Force. <https://www.drugsandalcohol.ie/30063/>

Client perspectives on barriers to progressing through methadone maintenance treatment in Ireland

Opiate use disorder (OUD) is a problem worldwide.¹ European statistics show that there are approximately 1.3 million high-risk opioid users in the EU, where opioids are found in 82% of fatal overdoses.² The most recent Irish data from 2014 estimated that there were 18,988 opiate users in the Republic of Ireland, giving a rate of 6.18 per thousand population aged 15–64 years (95% CI: 6.09–6.98).³

Methadone has ideal properties for the long-term treatment of OUD. A single dose of methadone overpowers the symptoms of opioid withdrawal for 24–36 hours without producing analgesia, sedation or euphoria.⁴ In Ireland, at year-end 2016, there were 80 Health Service Executive (HSE) methadone specialist centres in operation, treating 5,438 clients.⁵ However, of these clients, only 17 were appropriately stabilised and, as such, transferred to the lower-risk community setting. This represented only 2.2% of the potential transferrable client population.

A recent Irish study aimed to identify reasons as to why clients remain 'trapped' in the high-risk, specialist clinical setting.⁶ In this research, published in the journal *BMC Health Services Research*, qualitative semi-structured interviews were undertaken with 17 clients of one of Ireland's HSE Drug and Alcohol Services. Each client had a severe OUD and had spent on average 7.5 years engaging with the methadone maintenance treatment programme.

Results

Participants' life journey prior to an OUD included adverse childhood experiences (ACEs) and early exposure to illicit drug use. It was found that factors resulting in clients initiating and sustaining an OUD involved continuous hardship into adulthood, mental illness, and concurrent benzodiazepine use disorder, with subjects stating that these often resulted in loneliness and lack of life purpose. Living environments, a mistaken

understanding of their illness, and poor communication with allied health professionals further perpetuated their OUD. Participants stated that positive factors influencing periods of abstinence were familial incentives and a belief in the efficacy of methadone. Clients' own suggestions for improving their journeys included employing a multisectorial approach to managing OUD and educating themselves and others on opioid agonist treatments. If clients were not progressing appropriately, they themselves suggested enforcing a 'time-limit' to engage with the programme or for their treatment to be postponed.

Conclusions

The authors noted that methadone maintenance treatment is ideally placed to work collaboratively with public health in order to access and support vulnerable, high-risk individuals subjected to ACEs. They concluded that a cross-departmental, intergovernmental approach to address substance misuse as a societal issue as a whole is needed. In addition, it was recommended that subsequent work needs to be done on tackling vulnerable children's exposure to illicit drug use, concurrent benzodiazepine use in individuals with OUD, their housing conditions, and their lack of life purpose and loneliness.

Seán Millar

- 1 Teoh Bing Fei J, Yee A and Habil MH (2016) Psychiatric comorbidity among patients on methadone maintenance therapy and its influence on quality of life. *Am J Addict*, 25(1): 49–55.
- 2 European Monitoring Centre for Drugs and Drug Addiction (2016) *European drug report 2016: trends and developments*. Luxembourg: Publications Office of the European Union. <https://www.drugsandalcohol.ie/25579/>
- 3 Hay G, Jaddoa A, Oyston J, Webster J and Van Hout MC (2017) *Estimating the prevalence of problematic opiate use in Ireland using indirect statistical methods*. Dublin: National Advisory Committee on Drugs and Alcohol. <https://www.drugsandalcohol.ie/27233/>
- 4 Stotts AL, Dordill CL and Kosten TR (2009) Opioid dependence treatment: options in pharmacotherapy. *Expert Opin Pharmacother*, 10(11): 1727–40.
- 5 Department of Health (2016) *Central Treatment List: summary report for HSE Mid-West clinic. Jan 2016–Dec 2016 inclusive*. Dublin: Health Service Executive.
- 6 Moran L, Keenan E and Elmusharaf K (2018) Barriers to progressing through a methadone maintenance treatment programme: perspectives of the clients in the Mid-West of Ireland's drug and alcohol services. *BMC Health Serv Res*, 18(1): 911. <https://www.drugsandalcohol.ie/30195/>

Profiles of Irish psychiatric inpatients with no fixed abode

Recent research has shown that the number of emergency hospitalisations among those experiencing homelessness in Ireland has increased significantly in the last 10 years.¹ The

profile of those using emergency department services suggests that they are, in the main, chronically or episodically homeless and thus represent a relatively small proportion of the overall homeless population. Nevertheless, these subjects are heavy users of various costly services. Furthermore, a number of Irish studies have suggested that homeless people exhibit relatively high levels of mental health difficulties and may be over-represented in psychiatric settings.^{1,2}

Recent Irish research aimed to examine the profile of psychiatric admissions for subjects with no fixed abode.³ In this study, published in the *Irish Medical Journal*, the authors retrospectively evaluated the Health Research Board's National

Profiles of Irish psychiatric inpatients with no fixed abode

continued

Psychiatric Inpatient Reporting System (NPIRS) data to develop an overview of admissions with no fixed abode recorded for the years 2007–2016 (n=2176).

Results

It was found that in the 10-year period there was a 44% increase in admissions with no fixed abode from 188 in 2007 to 271 in 2016. The analysis demonstrated that the characteristics of this cohort have remained largely unchanged in the 10 years; almost three-quarters (1,598; 73.4%) were male, almost one-half (1,068; 49.1%) were less than 35 years of age, and three-quarters (1,638; 75.2%) were less than 45 years. Other characteristics of psychiatric inpatients with no fixed abode included the following:

- Three-quarters (1,643; 75.5%) were single and a similar proportion were unemployed (1,640; 75.4%).
- 621 (28.5%) had a diagnosis of schizophrenia, 258 (11.9%) had a depressive disorder, while 212 (9.7%) had a personality/behavioural disorder.
- 257 (11.8%) had an alcohol disorder, while 333 (15.3%) had other drug disorders.

Conclusions

The authors noted that these characteristics are consistent with the single 'chronically homeless' people described in the literature. In addition, it was observed that the prevalence of schizophrenia and alcohol and drug disorders differed from the national profile of psychiatric admissions.⁴ The authors concluded that there is a need to use routinely collected data to help understand and address the needs of specific homeless subgroups. In particular, it needs to address those on institutional circuits that include psychiatric inpatient facilities.

Seán Millar

- 1 O'Sullivan E (2008) Researching homelessness in Ireland: explanations, themes and approaches. In Downey D (ed) *Perspectives on Irish homelessness: past, present and future*. Dublin: Homeless Agency. <https://www.drugsandalcohol.ie/11723/>
- 2 Keogh C, O'Brien KK, Hoban A, O'Carroll A and Fahey T (2015) Health and use of health services of people who are homeless and at risk of homelessness who receive free primary health care in Dublin. *BMC Health Serv Res*, 15(1): 58. <https://www.drugsandalcohol.ie/23533/>
- 3 Daly A, Craig S and O'Sullivan E (2019) A profile of psychiatric inpatient admissions with no fixed abode (NFA) 2007–2016. *Ir Med J*, 112(1): 853. <https://www.drugsandalcohol.ie/30179/>
- 4 Daly A and Craig S (2017) *Irish psychiatric units and hospitals census 2016: main findings*. Dublin: Health Research Board. <https://www.drugsandalcohol.ie/26559/>

Public awareness of alcohol-related health conditions in Ireland: findings from the Healthy Ireland Survey

Alcohol is one of the leading causes of death and disability worldwide. A causal relationship has been established between alcohol and over 60 health conditions, such as female breast cancer, bowel cancer, and high blood pressure.¹ Despite the growing evidence on the contribution of alcohol to the global burden of disease and mortality, research in other countries demonstrates poor public knowledge of the association between alcohol and a range of alcohol-related health conditions, including cancer.^{2,3} The aim of this research was to establish public knowledge of six alcohol-related health conditions in Ireland, namely liver disease, pancreatitis, stomach ulcers, high blood pressure, female breast cancer, and bowel cancer.

Methods

Data were generated from Wave 2 of the Healthy Ireland Survey, a nationally representative cross-sectional survey of adults aged 15 years or older in Ireland. A total of 7,498 respondents took part in Wave 2, with interviews completed between September 2015 and May 2016. More details on the sample and methodology can be found in the Healthy Ireland Wave 2 technical report.⁴

Respondents' knowledge of the link between the six alcohol-related conditions was measured by presenting the respondents with a showcard with the following question: 'Looking at this showcard, can you please tell me which of the following you are at increased risk of developing by drinking more than the recommended number of standard drinks in a week?' The options presented on the showcard were: liver disease; pancreatitis; stomach ulcers; high blood pressure; female breast cancer; skin cancer; bowel cancer; all of these. The risk of developing skin cancer is not increased by consuming alcohol. The risk of all other conditions on the list is increased by drinking more than the recommended standard drinks in a week.

Findings

Respondents' awareness of the six alcohol-related health conditions broken down by gender is displayed in Figure 1. With the exception of liver disease (90.5%), knowledge of the link between alcohol and all other alcohol-related conditions was poor, ranging from 21.2% for breast cancer to just over 50% for high blood pressure. Some 14.1% of respondents

Public awareness of alcohol-related health conditions continued

identified alcohol consumption as a risk for developing skin cancer, despite no such evidence existing to support this link. Some 10.1% also incorrectly identified that ‘all of these’ conditions were related to excessive alcohol consumption. With the exception of high blood pressure, females’ awareness of alcohol-related conditions was slightly better than that of

males. However, a higher proportion of females also incorrectly reported an association between alcohol consumption and skin cancer and ‘all of these’ conditions.

The age breakdown of responses is presented in Figure 2. For most of the alcohol-related health conditions, with the exception of bowel cancer, awareness was highest among those aged 35–64. Overall, the age differences were relatively small. In particular, however, the low awareness of alcohol-related conditions among the youngest age bracket is of concern given that they are the group which has been shown to report the highest rates of hazardous and harmful drinking patterns.⁵

Figure 1: Proportion of males and females who reported selected health conditions are related to consuming more than the recommended number of standard drinks in a week

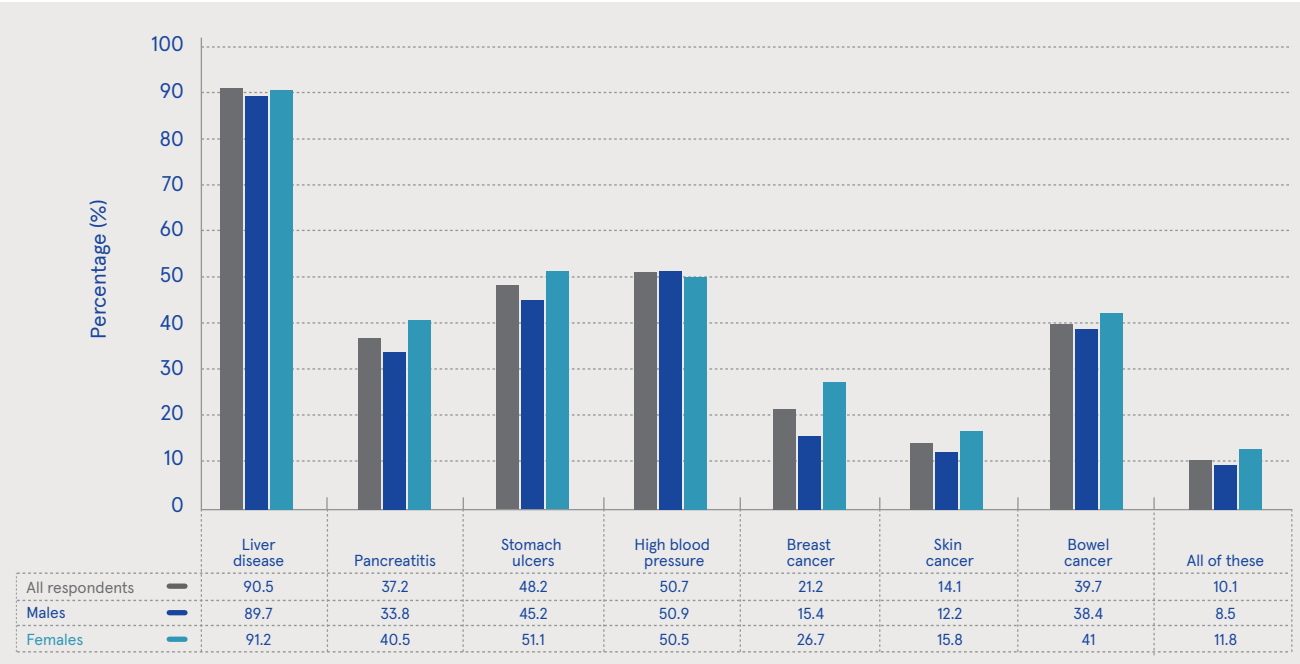
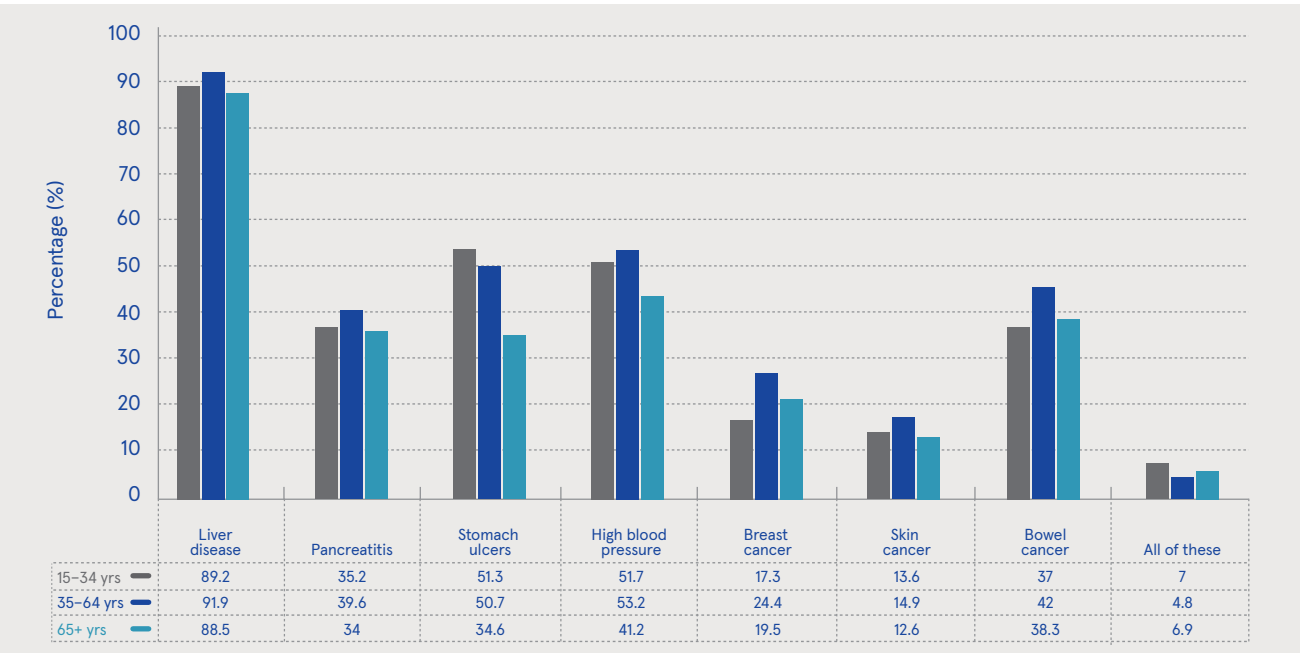


Figure 2: Proportion of respondents who believe selected health conditions are related to consuming more than the recommended number of standard drinks in a week, broken down by age



Public awareness of alcohol-related health conditions continued

Claire O'Dwyer and Deirdre Mongan

Conclusions

With the exception of liver disease, public awareness that alcohol can increase the risk of developing a variety of health conditions is low. Awareness varied greatly across specific conditions, with approximately one-half of the public being aware that increased alcohol consumption is linked to high blood pressure, compared with less than one-quarter being aware of the link between alcohol consumption and female breast cancer.

The poor public awareness of alcohol-related conditions and in particular of alcohol-related cancers is of concern. In Ireland, between 2001 and 2010, some 4,585 (4.7%) male and 4,593 (4.2%) female invasive cancer diagnoses were attributable to alcohol, while 2,823 (6.7%) of male cancer deaths and 1,700 (4.6%) of female cancer deaths were attributable to alcohol.⁶ Despite these figures, it is clear that the general public are not aware of the potential risks associated with increased alcohol consumption. The findings from this study provide support for the timely implementation of health warning labels on alcohol products as set out in the Public Health (Alcohol) Act 2018.

- 1 Griswold MG, Fullman N, Hawley C, Arian N, Zimsen SR, Tymeson HD, *et al.* (2018) Alcohol use and burden for 195 countries and territories, 1990–2016: a systematic analysis for the Global Burden of Disease Study 2016. *Lancet*, 392(10152): 1015–35. <https://www.drugsandalcohol.ie/29555/>
- 2 Buykx P, Gilligan C, Ward B, Kippen R and Chapman K (2015) Public support for alcohol policies associated with knowledge of cancer risk. *Int J Drug Policy*, 26(4): 371–79.
- 3 Buykx P, Li J, Gavens L, Hooper L, Lovatt M, de Matos EG, *et al.* (2016) Public awareness of the link between alcohol and cancer in England in 2015: a population-based survey. *BMC Public Health*, 16(1): 1194. <https://www.drugsandalcohol.ie/26464/>
- 4 Ipsos MRBI (2016) *Healthy Ireland Survey 2016: technical report*. Dublin: Stationery Office.
- 5 Department of Health (2018) *Healthy Ireland Survey 2018: summary of findings*. Dublin: Stationery Office. <https://www.drugsandalcohol.ie/29851/>
- 6 Laffoy M, McCarthy T, Mullen L, Byrne D and Martin J (2013) Cancer incidence and mortality due to alcohol: an analysis of 10-year data. *Ir Med J*, 106(10): 294–97. <https://www.drugsandalcohol.ie/21068/>

RESPONSES

A systems perspective on drug prevention

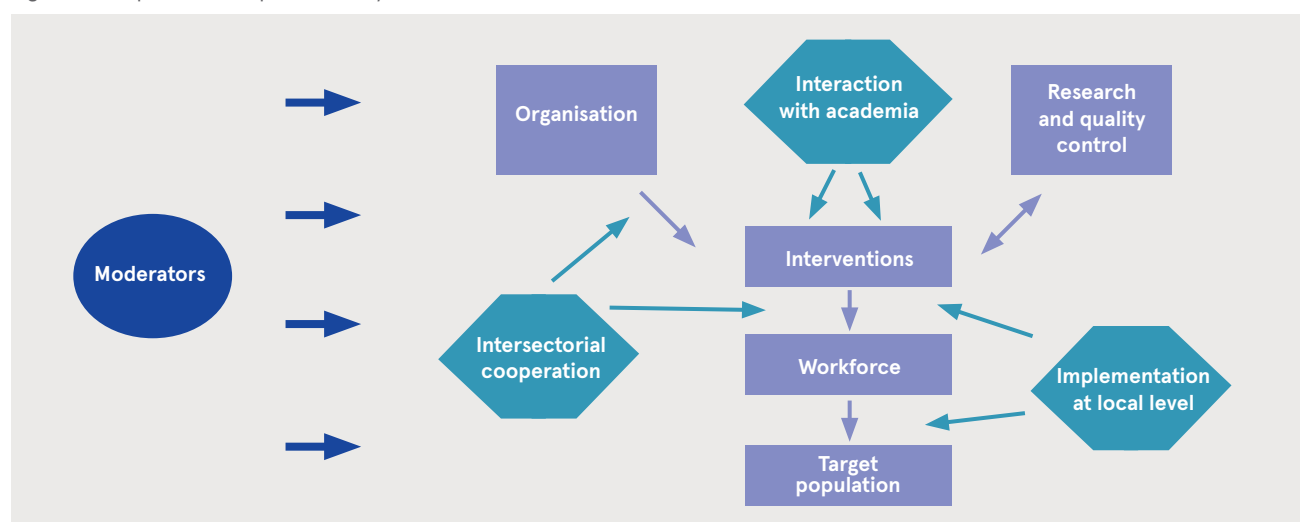
In March 2019, the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) published *Drug prevention: exploring a systems perspective*, as part of its Technical Report series.¹ Drawing on systems theory, the report considers substance use

prevention in Europe through the lens of a system. A system is described as being made up of 'a set of elements organised for a common purpose that are connected and interact with each other to form an integrated whole' (p. 6). By taking this approach, the report highlights the wide range of factors that need to be considered when implementing substance use prevention programmes and policies.

Prevention system model

Data gathered from the Reitox National Focal Points, as part of the EMCDDA's annual reporting cycle, were used to develop a model of an overall prevention system (see Figure 1). It is proposed as a starting point for comparing and analysing national or regional approaches to prevention, and reflects how prevention is conceived, organised, and delivered across the member states, as well as how the components interact. The five commonly accepted components of a prevention

Figure 1: Components of a prevention system



A systems perspective on drug prevention continued

system featured in the model are each explored in the report using analysis of the Reitox data. For the purpose of this article, each component is described alongside a selection of the related findings.

1. Organisation

The authors focus on three aspects of how prevention delivery is organised:

- **Decision-making** – where decision-making happens, how evidence is used in the process, and how local needs are assessed. In relation to the second, of these a need was identified for a better understanding of how research and policy interact, and for researchers to become more attuned to the needs of policymakers and practitioners. Having an assessment of local needs was described as a feature often lacking in the area of prevention, in particular when compared with the fields of treatment and harm reduction.
- **Intersectorial cooperation** – how/if it occurs and the conflicting views and priorities that exist. While there may formally be a drug coordinating role or body in a country, this did not necessarily result in coordination in practice. Barriers included the conflicting priorities within a country's governing bodies; for example, between the revenue produced by the sale of addictive goods, such as alcohol, and the health costs associated with its use.
- **Funding** – how prevention is funded and why certain activities may be funded and not others. While the sources of funding for prevention across Europe varied, data on funding and how decisions are based on them was described as 'scarce' (p. 15).

2. Research and quality assurance

Having the capacity to translate scientific findings, effective interventions, and principles of effectiveness into practice and existing services is described as 'one of the most vital features of a prevention system' (p. 17). The authors identify a number of challenges in doing so, which include:

- A lack of knowledge among stakeholders about the evidence of what works in prevention.
- The focus of the (largely North American) evidence base on manualised activities presents challenges in the European context. A need is identified for more focus on how to translate evidence into practice and evidence on non-manualised activities.

3. Interventions

The authors note that in order to be of use in the prevention field, the systems approach needs to take account of interventions of all forms (universal, selective, and indicated) and functions (developmental, environmental, and informational) that currently feature in the debate. They identify one of the main debates among prevention professionals in Europe to be 'whether manual-based programmes should be scaled up or emphasis should instead be given to local solutions that fit the particular circumstances of the culture, problem and infrastructure' (p. 21).

The prevention field in Europe and the range of interventions delivered is complex. Manual-based programmes, selective and indicated services, and environmental policies are discussed in this section of the report 'to showcase the different perspectives and priorities that a systems approach to prevention is able to incorporate' (p. 19). It was found that a distinctive feature of European prevention systems is that manual-based interventions often do not play a significant role. The authors explored the focus of each member state's prevention activities, asking whether they focused more on environmental policies or manualised programmes; Ireland was found to put more emphasis on the former.

Another key issue identified under interventions was that while there is often overlap between the determinants of different problem behaviours (e.g. substance use and violence/delinquency) and therefore the possible prevention interventions that could affect change, because they fit under different political portfolios, these commonalities are not understood and opportunities to have an impact are missed.

4. Workforce

This component covers the numbers in the workforce, the types of individuals, and the skills they have. Overall, the prevention workforce is diverse and finding information on its composition and training was described as 'difficult' (p. 23). It was noted that there is no agreed means to monitor the quality of prevention work and there was no common professional profile of a prevention worker. The need for standards and training for those working in the area was highlighted.

5. Target population

The recipients of prevention are a critical component of any system, not only as recipients but also in the development of interventions. As mentioned above, assessing local needs is often lacking from prevention systems. Other issues identified that need to be considered when selecting suitable and relevant interventions included the level of social exclusion experienced by the target population and the acceptability of programmes by the target population.

Alongside the five components laid out above was a set of moderators that influence the interaction between the components. These included: social inequality; social capital; social norms; alcohol and tobacco policies; and drugs legislation.

Concluding comment

This report is not a 'how to' guide on prevention, but rather through the experiences of member states provides a useful starting point for looking at core components of prevention systems and how they interact. It raises a number of interesting themes for prevention in the Irish context. For example: promoting and advancing a comprehensive definition of prevention; making links between substance use prevention and other behaviours; the relationship between funding and quality assurance; skills development and training for prevention professionals; and decision-making about interventions at national, regional and local level.

Lucy Dillon

1 European Monitoring Centre for Drugs and Drug Addiction (EMCDDA) (2019) *Drug prevention: exploring a systems perspective. Technical Report*. Luxembourg: Publications Office of the European Union. <https://www.drugsandalcohol.ie/30362/>

Second National Intracultural Health Strategy, 2018–2023

The *Second National Intracultural Health Strategy* (NIHS) 2018–2023 has been published by the Health Service Executive (HSE).¹ It will enable the HSE to better address the needs of service users of all ethnic and cultural backgrounds. The strategy is in response to the increasing diversity of people living and accessing health services in Ireland. Census 2016 showed that 17% of the population were not born in Ireland, representing 500,000+ individuals from 200 different countries (p. 13).¹

This strategy was developed through a process of consultation with community networks and sections within the HSE. The subsequent submissions were analysed and eight areas were identified, ranging from access to interpreting and translation, gender-based violence, and implementation of the second NIHS.²

Focus of first NIHS

The second strategy aims to build on the achievements of the first strategy (2007–2012).³ The first strategy looked to target access to services, develop the cultural competence of staff, and improve the evidence base around intracultural health needs. It was a comprehensive document that covered many of the key issues related to meeting the health needs of ethnic minority service users. Unfortunately, its publication coincided with the economic recession and significant restrictions on funding for many areas. Despite this, in 2016, a review of the strategy showed that 20 of its 43 actions had been completed. Achievements were made, for example, in capacity building, cultural competence of staff, and development of culturally appropriate resources. The least progress was made in the key area of data collection and analysis, even though this was identified as a key pillar of the first strategy. Of note, the National Drug Treatment Reporting System (NDTRS) is one of the few national data collection systems to successfully collect aggregated data on ethnicity (including Roma), country of birth, and main language.⁴

Focus of second NIHS

The focus of the first strategy was concentrated on newly arrived ethnic minority people, often seeking international protection. The second strategy seeks to address the healthcare needs of migrants⁵ who have made Ireland their home not only in recent times but over the past few years, as well as members of the Traveller and Roma communities. In 2017, the Department of Justice and Equality published the *National Traveller and Roma Inclusion Strategy, 2017–2021*⁶ specifically for these communities and, while the NIHS does not seek to duplicate actions, Roma in particular are also highlighted in this strategy in relation to their health needs.

Implementation: goals and objectives

There will be a detailed implementation plan for the strategy with the aim of reviewing progress mid-term in 2020/2021. The

goals and objectives of the second strategy (2018–2023) are reproduced below (p. 21).

Goal 1

Enhance accessibility of services to service users from diverse ethnic, cultural and religious backgrounds.

Strategic objectives:

- Provide information in accessible, culturally responsive ways.
- Develop a model for interpreting provision across the HSE.
- Develop an evidence-informed system of translating information.

Goal 2

Address health issues experienced by service users from diverse ethnic, cultural and religious backgrounds.

Strategic objectives:

- Implement cross-government obligations in respect of health needs of service users.
- Implement national obligations in relevant cross-departmental strategies.
- Promote a model of health screening and prevention.
- Address health inequalities relevant to service users in relation to oral health, sexual health, reproductive health, children and young people, LGBTI+, disability, men, mental health and palliative care.

Goal 3

Ensure provision of high-quality, culturally responsive services to service users from diverse ethnic, cultural and religious backgrounds.

Strategic objectives:

- Provide intercultural awareness training to all relevant staff, and take into account the needs of staff who work with a diverse population.
- Ensure that services are planned and delivered in a context of cultural competence and in line with requirements of the public sector duty and related obligations.

Goal 4

Build an evidence base.

Strategic objective:

- Work towards the development of high-quality data collection, monitoring and evaluation to build an evidence base on minority ethnic health and ensure evidence-informed practice.

Goal 5

Strengthen partnership working to enhance intercultural health.

Strategic objective:

- Actively promote participation of service users from minority ethnic groups in the design, planning, delivery and evaluation of services.

Second National Intracultural Health Strategy, 2018–2023 continued

Suzi Lyons

- 1 Health Service Executive (HSE) (2018) *Second National Intracultural Health Strategy 2018–2023*. Dublin: HSE. Available online at: <https://www.hse.ie/eng/about/who/primarycare/socialinclusion/intercultural-health/intercultural-health-strategy.pdf>
- 2 An overview of the consultation process can be found on pages 38 and 39 of the strategy, along with a summary of the submissions and analysis of the consultation in Appendix 4 (p. 100).
- 3 Health Service Executive (HSE) (2008) *National Intracultural Health Strategy 2007–2012*. Dublin: HSE. Available online at: <https://www.hse.ie/eng/services/publications/socialinclusion/national-intercultural-health-strategy-2007---2012.pdf>

4. For further information on the NDTRS, visit: <https://www.hrb.ie/data-collections-evidence/alcohol-and-drug-treatment/how-data-is-collected/>
- 5 The term 'migrant' is defined by the International Organization for Migration (IOM) as 'any person who is moving or has moved across an international border or within a State away from his/her habitual place of residence, regardless of (1) the person's legal status; (2) whether the movement is voluntary or involuntary; (3) what the causes for the movement are; or (4) what the length of the stay is'. For further information, visit: <https://www.iom.int/who-is-a-migrant>
- 6 Department of Justice and Equality (2017) *National Traveller and Roma Inclusion Strategy 2017–2021*. Dublin: Department of Justice and Equality. Available online at: <http://www.justice.ie/en/JELR/National%20Traveller%20and%20Roma%20Inclusion%20Strategy,%202017-2021.pdf/Files/National%20Traveller%20and%20Roma%20Inclusion%20Strategy,%202017-2021.pdf>

Policing with local communities

In December 2018, the Minister for Justice and Equality published the Garda Inspectorate's *Policing with local communities* report.¹ The Policing Authority (PA) was tasked with overseeing this review and worked alongside the Garda Síochána Inspectorate (GSINSP), who are responsible for ensuring that the resources available to An Garda Síochána (AGS) 'are used so as to achieve and maintain the highest levels of efficiency and effectiveness in its operation and administration, as measured by reference to the best standards of comparable police services' (s. 117).² The terms of reference agreed by PA and GSINSP examined:

- The changing environments in rural, developing urban and suburban areas
- Views of local communities
- Allocations of Garda resources and their deployment at the local policing level, including the use of the Garda Reserve, Garda facilities and Garda equipment, and
- Relevant recommendations made in previous Inspectorate reports (p. 2).

Methodology

Over 40 areas were examined in the course of this investigation. Data were collected using a range of methods and analysed, for example:

- Formal information and data requests to AGS
- Statistical data from the PULSE (Police Using Leading Systems Effectively) system
- Self-report questionnaires
- Field visits to headquarters, divisions (n=8), districts, and national units
- Meetings with key stakeholders
- Public consultations and meetings attended on the future of policing in Ireland

- Engagement with other policing jurisdictions and agencies
- Implementation reports on *Changing policing in Ireland* (2015)³
- Desk-based research.

Issues raised

The local policing issues raised by the terms of reference were categorised thematically into four areas: strategic perspective; resource allocation, availability and use; resource deployment and capability; and delivering local services. What follows are examples of some of the key issues identified by the Inspectorate within these categories.

Strategic perspective

This section examined the factors that impact on the demand for policing services, how it is understood, assessed, and managed from a strategic perspective. The report identified changes in Ireland's demographic profile along with environmental factors, such as serious and organised crime, climate change and Brexit, as areas that influenced policing priorities. To address these issues effectively and to determine the most appropriate strategy and workforce required, it is critical that AGS understands and measures the demand for its services. The importance of drawing on intelligence-led policing was emphasised, particularly in the area of threat, risk, and harm assessment to help prioritise policing actions. At the time of this review, this was not done in Ireland.

Resource allocation, availability and use

How Garda resources were used and allocated to provide effective, visible and responsive services to the community was examined. The review indicated that AGS does not have an appropriate human resource system to assist in the assignment and management of staff. Gardaí are currently assigned to divisions via the Cohort allocation model, which considers factors such as population, number of stations, and crime and non-crime incidents recorded on PULSE. This is not an evidence-based model. Notably, at the time of this review, data from Cohort indicated that the number of gardaí allocated to divisions was either in excess or lower than what was operationally required. Moreover, it was also evident that the number of gardaí on duty was inadequate to

Policing with local communities

continued

meet local policing needs, particularly in rural areas. Despite previous recommendations by the Inspectorate in 2015, a large number of trained members were still in non-operational posts instead of carrying out frontline duties. Moreover, gardaí were constantly taken away from core duties, rendering them unavailable for patrol or visibility. With regard to custody facilities, many do not have the right equipment and are not in secure areas.

Resource deployment and capability

The Inspectorate examined how AGS identified local demand and how it determined whether resources should be deployed to provide a visible, effective and responsive service locally. Barriers identified that prevented good resource planning and demand management included poor-quality service calls and data due to inconsistent recording by members, particularly for domestic incidents. While there was some evidence of good practice for structured briefing, tasking, and debriefing, generally this practice was absent. In contrast to other jurisdictions, duty planning in AGS is paper based, managed district by district, and the existing Garda rota uses a one-size-fits-all approach. The report indicated that no national policy exists to determine how different types of service calls nor different types of crimes for investigation should be assigned. Moreover, vulnerability of victims is only aligned to certain crime types and support is only provided to victims that meet Garda policy vulnerability criteria.

Delivering local services

Engagement with communities and stakeholders and how AGS responds in the delivery of services were examined. While positive steps were being taken to include communities in policing and to make areas safer, this was not coordinated at a national level. In addition, the approaches used varied. Public consultation was evident; however, opportunities to implement a more interactive approach was underdeveloped. Positively, as per previous Inspectorate recommendations, practices and procedures for engaging with victims of crime have improved. For example, Garda Victims Services Offices have been introduced in all divisions and PULSE has been modified to record details of contact with victims. That being said, policies and procedures to support repeat victims of crime have not yet been implemented. The issue of rural crime and fear of crime has also been raised. The geography and rural isolation cause problems for AGS, which is further exacerbated by station closures in rural areas and reduced availability of community policing gardaí.

Critical actions

The Inspectorate identified nine critical actions that are considered essential to ensuring that Irish policing services provided to the community are efficient, visible, accessible and responsive:

- 1 Evidence-based methodologies and processes that enable AGS to understand current and future demand and inform identification of its policing priorities
- 2 Organisational structures, strategies and plans that enhance the delivery of local policing services
- 3 Evidence-based resourcing model that allows accurate allocation of resources based on policing need in areas of

higher threat, risk, harm, and vulnerability

- 4 Organisational visibility and accessibility strategy, supported by divisional implementation plans to enhance public confidence and take policing to the public
- 5 Maximum availability of human resources at local policing levels
- 6 Policies, processes and systems to ensure effective deployment of resources at a local level
- 7 Capability of the local policing workforce through the provision of relevant training programmes, better supervision, and the use of new technologies
- 8 Strategies, processes and action plans to improve delivery of local policing services
- 8a New guidance and training and funding for Joint Policing Committees and local community to provide increased accountability for and support to local policing
- 9 Implementation of a full divisional model.

Conclusions

While critical actions were put forward, Chief Inspector Mark Toland of the Inspectorate stated that 'the Garda Síochána do many things well and their strong community ethos was reflected throughout this inspection and forms a strong foundation to develop a more structured and consistent approach to preventing harm in communities' (p. 1).⁴ The Minister for Justice and Equality has requested that this report should be referred to and considered in the work carried out by the Garda Commissioner and the Implementation Group on Policing Reform.⁴ This report was welcomed by the Policing Authority who believe that it will make an extensive contribution to the ongoing work in this area.⁵

Ciara H Guiney

- 1 Garda Síochána Inspectorate (2018) *Report of the Garda Síochána Inspectorate: policing with local communities*. Dublin: Garda Síochána Inspectorate. <https://www.drugsandalcohol.ie/30115/>
- 2 Government of Ireland (2005) *Garda Síochána Act 2005*. Available online at: <http://www.irishstatutebook.ie/eli/2005/act/20/enacted/en/print.html>
- 3 Garda Síochána Inspectorate (2015) *Report of the Garda Síochána Inspectorate: changing policy in Ireland*. Dublin: Garda Síochána Inspectorate. <https://www.drugsandalcohol.ie/29426/>
- 4 Garda Síochána Inspectorate (2018) *Press release: publication of Garda Inspectorate Report 'Policing with Local Communities'*. Dublin: Garda Síochána Inspectorate. Available online at: http://www.gsinsp.ie/en/GSINSP/Pages/press_releases
- 5 Policing Authority (2018) *Publication of Garda Inspectorate report 'Policing with local communities'*. Dublin: Policing Authority. Available online at: <https://www.policingauthority.ie/en/all-media/news-detail/publication-of-garda-inspectorate-report-policing-with-local-communities>

End-of-life care for people with alcohol and drug problems

This rapid evidence assessment set out to determine the availability and quality of international research evidence on the subject of end-of-life care for people with alcohol and drug problems.¹ There have been significant changes in the population of people with substance use problems. These include an increase in the number of older drug users and deaths in this population that are non-drug related and an increase in alcohol-related morbidity and mortality in older users.

The review gathered together any research/evidence in the current responses to end-of-life care for this cohort, identifying gaps in the evidence, highlighting examples of good practice, and suggesting future directions for the research.

A significant gap in evidence on this topic was quickly identified, with a complete lack of evidence specifically on effective interventions, responses or models of practice, with no agreement as to what constitutes best practice for this group of people. As a result, the authors had to broaden their scoping of the evidence and instead produced a systematic map of the evidence available.

A final sample of 60 papers was included in this evidence review. Of these 60 papers, 32 reported empirical evidence. Applying quality assessment measures to these 32 papers, 9 were determined to be of high quality, 18 were of moderate quality, and 5 were of low quality. Most of the papers came from North American countries, with two-thirds of the papers quantitative in approach. Only 11 of the papers were qualitative studies. Three main areas/themes were covered in these papers, namely, pain management, homeless and marginalised populations, and alcohol related.

Recommendations

The systematic map highlighted the significant gap in research

and evidence in this area, with a particular gap in qualitative evidence from either service users or providers. Of the papers covered in this review, recommendations on best practices that were contained within the papers were gathered. There were some common recommendations relating to safe and effective pain management strategies and harm reduction strategies. Some of the recommendations for pain management included the use of screening tools and active monitoring of people using substances. For alcohol-related issues, recommendations included highlighting the need for awareness of alcohol withdrawal at the end of life and the need for routine alcohol assessment among these patients. Recommendations looking at homeless substance users included the provision of alcohol and care in shelter environments, safety plans, and supervised drug consumption.

Challenges and evidence gaps

This review also highlighted some of the challenges faced by care workers providing services in this area, which may have an impact on implementing the recommendations above. There were concerns about achieving safe and effective pain management in the context of a person's substance abuse and managing 'lifestyle factors' that may be associated with substance abuse. These may involve certain behaviours, experiences, and anxieties that people bring to the service and can be difficult to manage. The review also highlighted the underutilisation of primary care services in this population but with a subsequent overutilisation of emergency services, with short admissions and premature self-discharge. This trend leads to receiving terminal diagnoses at a late stage of the disease, reducing the ability to plan for high-quality care in this area.

The significant gaps identified in this review clearly show that this is an area where further research is needed to provide a better evidence base, which will help to develop better end-of-life care for people with alcohol and drug problems.

Helen Kennelly

- 1 Witham G, Peacock M and Galvani S (2018) *End of life care for people with alcohol and drug problems: rapid evidence assessment*. Manchester: Manchester Metropolitan University. <https://www.drugsandalcohol.ie/30056/>

Opioid dependence: buprenorphine prolonged-release injection (Buvidal)

An evidence summary was commissioned by Public Health England to examine the therapeutic potential of buprenorphine prolonged-release injection as an alternative opioid dependence treatment to the current treatment of daily sublingual buprenorphine-naloxone.¹ Buprenorphine prolonged-release injection is an opioid agonist/antagonist and

is administered as a weekly or monthly subcutaneous injection. Buprenorphine injection may be an alternative treatment option for opioid addiction where people have difficulties following a daily supervised opioid substitution and also where there is a potential safety risk of storing medicines at home.

A recent randomised control trial² demonstrated that, overall, people using buprenorphine prolonged-release injection were no less likely to have opioid-negative urine samples or respond to treatment in comparison with people receiving sublingual buprenorphine-naloxone. Similar adverse effects were reported for both treatments. A major safety issue to consider is the long duration of action of buprenorphine with the prolonged release of the injection, when considering the length of treatment needed to reverse the effects of overdose.

The trial evidence presented has certain limitations. The trial was conducted in United States healthcare settings, with only

Buprenorphine prolonged-release injection continued

one of the study sites a primary care setting. This may limit the applicability of this treatment in these settings. The primary outcomes assessed from the trial were disease orientated. Patient-orientated outcomes, such as craving and withdrawal scores, were investigated as exploratory outcomes only. As participants were paid to take part in this study, the reported retention rates may not accurately reflect retention rates in practice.

Mental health, pharmacy, medicines management, and health and justice specialists were asked for their views on using buprenorphine prolonged-release injection in practice. They stated that it may be an alternative treatment option in certain cases, but suggested barriers to its use. Some of these included the cost of injection, training and additional staff resources, lack of clarity about treating overdose, and service user preference.

For service users, some of the suggested advantages included

service user convenience, reduced accidental poisonings, and a greater flexibility to engage in work or study. While some of the disadvantages include the need to attend a clinic for the injection and a reduction in pharmacy interaction, leading to a potential reduction in the ability to quickly identify health issues with the service user.

Overall, buprenorphine prolonged-release injection is a possible alternative therapy for a specific small cohort. However, a significant change in the care pathway would be needed to facilitate this instead of the usual sublingual treatment.

Helen Kennelly

- 1 National Institute for Health and Care Excellence (NICE) (2019) *Opioid dependence: buprenorphine prolonged-release injection (Buvidal)*. London: NICE.
<https://www.drugsandalcohol.ie/30270/>
- 2 Lofwall MR, Walsh SL, Nunes EV, *et al.* (2018) Weekly and monthly subcutaneous buprenorphine depot formulations vs daily sublingual buprenorphine with naloxone for treatment of opioid use disorder: a randomized clinical trial. *JAMA Intern Med*, 178(6): 764–73.

National Drugs Forum 2019

Inclusion Health:
Responding to Complex
Health Needs of People
Who Use Drugs

Croke Park Stadium
5 November 2019


An Roinn Sláinte
Department of Health

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Adolescent Addiction Service report, 2018

The Health Service Executive (HSE) Adolescent Addiction Service (AAS) provides support and treatment in relation to alcohol and drug use for young people and families from the Dublin suburbs of Ballyfermot, Clondalkin, Palmerstown, Lucan, and Inchicore. Services provided include advice, assessment, counselling, family therapy, professional consultations, and medications if required. In 2018, the AAS published a report detailing referrals for 2017.¹

Referrals

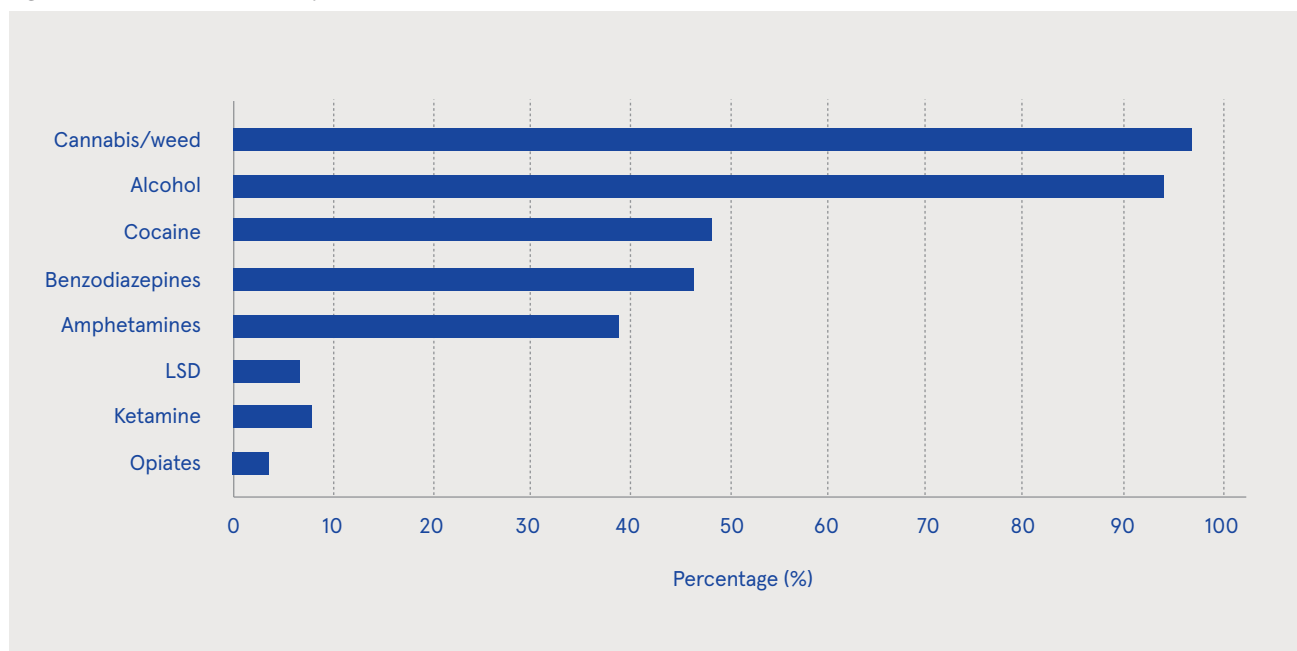
In 2017, the AAS worked with 44 young people and their

families, with a mean age of 15.5 years (range: 14–18 years). This figure includes new referrals, re-referrals and continuances. The majority (84%) were male and 9% were non-Irish nationals. In terms of referral areas, the greatest numbers of referrals were from Clondalkin (48%) followed by Lucan (23%), Ballyfermot (20%), Inchicore (7%), and Palmerstown (2%).

Drug and alcohol use

Cannabis/weed continued to be the main substance used by clients at 97%, while alcohol use was at 95% (see Figure 1). Other substances of use included cocaine (48%), benzodiazepines (46%), amphetamines (39%), LSD (7%), ketamine (7%) and opiates (4%) (including heroin and Solpadeine). Solvents and head-shop-type products did not feature among young people's substance use in 2017. The report noted that the biggest change concerning secondary drug use related to an increase in alcohol use by 35%, cocaine use by 19%, benzodiazepines by 13%, and amphetamines by 8%.

Figure 1: Main substances used by AAS clients, 2017



Source: HSE AAS, 2018

Other issues

Other issues presented related to indebtedness (30%) and absconding (40%), resulting in two young people accessing out-of-hours services. Additionally, seven young people had social work involvement and four had residential care placements. Hospital admission was high at 14% and 14% of people had a history of self-harm. Of those who exited treatment, 58% had a planned discharge, 27% declined further treatment, while 15% moved out of the community or returned to their community of origin. Of those who had planned discharges, less than 5% had onward referral to residential treatment or long-term residential aftercare. The majority of young people (82%) were seen by a family therapist only, with 18% having a psychiatric assessment.

Conclusions

The AAS report authors noted that, as in previous years, most young people had established patterns of substance use prior to referral (range: 1 month–4 years) and, as a consequence, some struggle to maintain a drug-free status. Nevertheless, most achieve stability and several remain abstinent. They concluded that there is a need for parents and non-parental adults to identify young people within risk groups at an early stage and to elevate concern for them.

Seán Millar

¹ Adolescent Addiction Service (2018) *Adolescent Addiction Service report 2018*. Dublin: Health Service Executive.
<https://www.drugsandalcohol.ie/29358/>



National Drugs Library

UPDATES

Recent publications

Mental healthcare interfaces in a regional Irish prison

Gulati G, Otuokpaikhian K, Crowley M, Pradeep V, Meagher D and Dunne CP (2019) *International Journal of Prisoner Health*, 15(1): 14–23.
<https://www.drugsandalcohol.ie/30319/>

The purpose of this paper is to study the demographic, clinical characteristics and outcomes for those prisoners referred to secondary mental healthcare in a regional Irish prison and the proportion of individuals diverted subsequently from prison to psychiatric settings.

The multifaceted need set of those referred strengthens the argument for the provision of multidisciplinary mental healthcare into prisons. The analysis of security needs for those diverted from prisons supports the need for Intensive Care Regional Units in Ireland.

The association between self-harm and area-level characteristics in Northern Ireland: an ecological study

Griffin E, Bonner B, Dillon CB, O'Hagan D and Corcoran P (2019) *European Journal of Public Health*, Early online.
<https://www.drugsandalcohol.ie/30361/>

This study took an ecological approach to examine the association between area-level factors and rates of self-harm in Northern Ireland.

These findings indicate that self-harm rates are highest for those residing in highly deprived areas, where unemployment, crime and low level of education are challenges. Community interventions tailored to meet the needs of specific areas may be effective in reducing suicidal behaviour.

Alcohol industry CSR organisations: what can their Twitter activity tell us about their independence and their priorities? A comparative analysis

Maani Hessari N, van Schalkwyk MCI, Thomas S and Petticrew Mark (2019) *International Journal of Environmental Research and Public Health*, 16(5): 892.
<https://www.drugsandalcohol.ie/30363/>

We conducted a content analysis of the health information disseminated by AI [alcohol industry]-funded organisations through Twitter, compared with non-AI-funded charities, to assess whether their messages align with industry and/or public health objectives.

These findings are consistent with previous evidence that the purpose of such bodies is the protection of the alcohol market, and of the alcohol industry's reputation. Their messaging strongly aligns with AI corporate social responsibility [CSR] goals. The focus away from health harms, particularly cancer, is also consistent with previous evidence. The evidence does not support claims by these alcohol-industry-funded bodies about their independence from industry.

Progress in adolescent health and wellbeing: tracking 12 headline indicators for 195 countries and territories, 1990–2016

Azzopardi PS, Hearps SJC, Francis KL, Kennedy EC, Mokdad AH, Kassebaum NJ, et. al (2019) *Lancet*, 393(10176): 1071–76.
<https://www.drugsandalcohol.ie/30368/>

Here, we present country-level estimates of 12 headline indicators from the *Lancet* Commission on adolescent health and wellbeing, from 1990 to 2016.

Although disease burden has fallen in many settings, demographic shifts have heightened global inequalities. Global disease burden has changed little since 1990 and the prevalence of many adolescent health risks have increased. Health, education, and legal systems have not kept pace with shifting adolescent needs and demographic changes. Gender inequity remains a powerful driver of poor adolescent health in many countries.

Recent publications continued

Is policy 'liberalization' associated with higher odds of adolescent cannabis use? A re-analysis of data from 38 countries

Stevens A (2019) *International Journal of Drug Policy*, 66: 94–99. <https://www.drugsandalcohol.ie/30392/>

The aim of this paper was to test the validity and reliability of Shi *et al.*'s conclusion that the HBSC [Health Behaviour in School-Aged Children] data show an association between policy 'liberalization' and increased likelihood of adolescent cannabis use.

Using a larger and more theoretically relevant sample of the HBSC respondents and an improved statistical model shows that the HBSC data do not reveal a statistically significant association between policy 'liberalization' and higher odds of adolescent cannabis use.

European Pain Federation (EFIC) position paper on appropriate use of cannabis-based medicines and medical cannabis for chronic pain management

Häuser W, Finn DP, Kalso E, Krceviski-Skvarc N, Kress HG, Morlion B, *et al.* (2018) *European Journal of Pain*, 22(9): 1547–64. <https://www.drugsandalcohol.ie/30410/>

This position paper provides expert recommendations for nonspecialist and specialist healthcare professionals in Europe, on the importance and the appropriate use of cannabis-based medicines as part of a multidisciplinary approach to pain management, in properly selected and supervised patients.

Codeine usage in Ireland – a timely discussion on an imminent epidemic

McDonnell E (2019) *Irish Medical Journal*, 112(3): 899. <https://www.drugsandalcohol.ie/30373/>

From a dual perspective as both a current medical student and practising community pharmacist, I note that codeine is an addiction that is often hidden under the guise of pain management, going unaddressed by both doctor and patient. Pain is a very common complaint in primary care settings in Ireland and the UK.

Profiling emergency department presentations of 14–15-year-olds in modern Ireland

Martin T, Corcoran A, Canty N, Dillon J, O'Reilly P, O'Donnell G, *et al.* (2019) *Irish Journal of Medical Science*, Early online. <https://www.drugsandalcohol.ie/30377/>

Mid-adolescence, that twilight era when the human child transitions to adulthood, is an often overlooked developmental age yet harbours a subpopulation of patients with their own myriad of medical problems somewhat unique to their age group.

The results highlight the most common presentations of this subgroup of patients, with trauma, in keeping with recent international data, being the most common presentation. The noted high frequency in the number of mental health/intoxication/self-harm presentations among the Irish teenagers in our region is consistent with trends reported in world literature and serves to emphasise one of the main challenges facing those working in paediatrics in Ireland over the next 10 years.

'HepCheck Dublin': an intensified hepatitis C screening programme in a homeless population demonstrates the need for alternative models of care

Lambert JS, Murtagh R, Menezes D, O'Carroll A, Murphy C, Cullen W, *et al.* (2019) *BMC Infectious Diseases*, 19(1): 128. <https://www.drugsandalcohol.ie/30408/>

The HepCheck study sought to investigate and establish the characterisation of HCV burden among individuals who attended an intensified screening programme for HCV in homeless services in Dublin, Ireland.

This study demonstrates that the current hospital-based model of care is inadequate in addressing the specific needs of a homeless population and emphasises the need for a community-based treatment approach. Findings are intended to inform HepCare Europe in their development of a community-based model of care in order to engage with homeless individuals with multiple co-morbidities including substance abuse, who are affected by or infected with HCV.

Cross-sectional study on the need to provide contraceptive services to women attending opioid-substitution therapy

Olioff J, O'Shea T, Horan A, Naughton AM and O'Brien D (2019) *Heroin Addiction and Related Clinical Problems*, Early online. <https://www.drugsandalcohol.ie/30420/>

This study aimed to assess the pregnancy history, contraceptive use and access to contraceptive services of women attending Cork-Kerry Community Healthcare (CKCH) for opioid replacement therapy. The need for a contraceptive service within the Addiction Services at CKCH was evaluated.

This study highlights the need to increase contraceptive services for women attending CKCH for opioid replacement therapy. Addiction services are ideal locations to also access contraceptive services because service-users already attend these clinics frequently for treatment, and thus have continuity of care with healthcare providers.

Recent publications continued

Trends in addiction treatment in Irish prisons using national surveillance data, 2009–2014

Cannon A, Nally F, Collins A, Fay R and Lyons S (2019) *International Journal of Prisoner Health*, 15(2): 105–113. <https://www.drugsandalcohol.ie/30318/>

The purpose of this paper is to analyse trends in addiction treatment demand in prisons in Ireland from 2009 to 2014 using available national surveillance data in order to identify any implications for practice and policy.

This is the first study to analyse treatment episodes in prison using routine surveillance data in Ireland. Analysis of these data can provide useful information, not currently available elsewhere.

The interaction between maternal smoking, illicit drug use and alcohol consumption associated with neonatal outcomes

Reynolds CME, Egan B, Daly N, McKeating A, Sheehan SR and Turner MJ (2019) *Journal of Public Health*, Early online. <https://www.drugsandalcohol.ie/30260/>

The adverse effects of smoking on neonatal outcomes, such as small-for-gestational-age (SGA), has been extensively studied; however, the consequences of smoking combined with alcohol and/or drug use is less clear.

Illicit drug use combined with maternal smoking during pregnancy increases the risk of adverse neonatal outcomes above that of smoking in isolation.

‘Do as we say, not as we do?’ the lifestyle behaviours of hospital doctors working in Ireland: a national cross-sectional study

O’Keeffe A, Hayes B and Prihodova L (2019). *BMC Public Health*, 19(1): 179. <https://www.drugsandalcohol.ie/30293/>

This study was conducted to assess the lifestyle behaviours of a national sample of hospital doctors working in Ireland. We also sought to compare the prevalence of these behaviours in doctors to the general Irish population.

While the prevalence of health behaviours amongst hospital doctors in Ireland compares favourably to the general population, their alcohol consumption and engagement in health enhancing physical activity suggest room for improvement. Continued health promotion and education on the importance of personal health behaviours is essential.

Excellent reliability and validity of the Addiction Medicine Training Need Assessment Scale across four countries

Pinxten WJL, Fitriana E, De Jong C, Klimas J, Tobin H, Barry T, et al. (2019) *Journal of Substance Abuse Treatment*, 99: 61–66. <https://www.drugsandalcohol.ie/30292/>

The aim of this study was to evaluate the psychometric properties of the addiction medicine AM-TNA Scale: an instrument specifically designed to develop the competence-based curriculum of the Indonesian AM course.

In our study the AM-TNA scale had a strong two-factor structure and proved to be a reliable and valid instrument. The next step should be the testing external validity, strengthening discriminant validity and assessing the re-test effect and measuring changes over time.

Epidemiology, clinical features and management of patients presenting to European emergency departments with acute cocaine toxicity: comparison between powder cocaine and crack cocaine cases

Miró O, Dargan PI, Wood DM, Dines AM, Yates C, Heyerdahl F, et al. (2019) *Clinical Toxicology*, 57(8): 718–26. <https://www.drugsandalcohol.ie/30207/>

The aim of this study was to analyse the epidemiology, clinical picture and emergency department (ED) management of a large series of patients who presented to European EDs after cocaine consumption, comparing data from powder (C₁ group) and crack (C₂ group) consumers.

Cocaine is commonly involved in European ED presentations with acute recreational drug toxicity, but there is variation across Europe not just in the involvement of cocaine but in the proportion related to powder versus crack. Some differences in clinical picture and ED management exist between powder cocaine and crack consumers.

You’re with your ten closest mates ... and everyone’s kind of in the same boat’: friendship, masculinities and men’s recreational use of illicit drugs

Darcy C (2018) *AMITY: The Journal of Friendship Studies*, 5(1): 43–57. <https://www.drugsandalcohol.ie/30254/>

Based on empirical sociological research, this article explores how some Irish men’s recreational use of illicit drugs, masculinities and friendship, interconnect. Drawing from in-depth interviews with twenty Irish men who identified as recreational users of illicit drugs, the article examines men’s drug taking within homosocial contexts as a friendship practice. By conceptualising masculinities as relational, socially constructed and fluid, the article examines social aspects of men’s drug taking as part of a pattern of gender practices used to establish, maintain and affirm men’s friendships. The findings of the research demonstrate men’s recreational use of illicit drugs forms part of the social practices of friendship among drug taking men, and men’s understandings of masculinity in turn influence these social practices.

Recent publications continued

The experience of the treatment demand indicator in Europe: a common monitoring tool across 30 countries

Montanari L, Pirona A, Guarita B, Hedrich D, Mounteney J and Vicente J (2019) *Journal of Studies on Alcohol and Drugs*, Suppl 18: 139–151.
<https://www.drugsandalcohol.ie/30226/>

The article describes an epidemiological indicator called Treatment Demand Indicator (TDI). The TDI aims to provide professionals and researchers with a common European methodology for collecting and reporting core data on drug users in contact with treatment services. The article discusses the implementation of the TDI in the European countries and describes the main results, limitations, and future perspectives.

The TDI is the largest drug dataset in Europe, and its data is increasingly used in European and national data analysis. The use of a common drug-treatment-monitoring tool across a group of countries provides a useful instrument for policymakers, professionals, and managers working in the drug treatment field.

Patterns of self-harm methods over time and the association with methods used at repeat episodes of non-fatal self-harm and suicide: a systematic review

Witt K, Daly C, Arensman E, Pirkis J and Lubman D (2019) *Journal of Affective Disorders*, 245: 250–64.
<https://www.drugsandalcohol.ie/30259/>

The risk of self-harm repetition and suicide may be influenced by self-harm method choice. However, there are mixed findings regarding whether there is a discernible pattern in self-harm methods over successive episodes of non-fatal self-harm, and if so, how these may be associated with self-harm repetition and/or suicide.

Given the frequency of method switching observed, and the lack of discernible patterns over time, all patients should be routinely assessed for risk and needs irrespective of the method used at the index episode of non-fatal self-harm.

Appraisal of international guidelines on smoking cessation using the AGREE II assessment tool

Quintyne KI and Kavanagh P (2019) *Irish Medical Journal*, 112(2): 867.
<https://www.drugsandalcohol.ie/30258/>

The aim of this study was to identify and evaluate the quality of methodological rigours and transparency used in guidelines for smoking cessation (for specific groups including: general adult population; persons with mental illness; and pregnant women).

Our findings have demonstrated higher scores among the most recent guidelines, reflecting improvement in the quality of guideline development over time. Methodology and editorial independence were particular concerns and this assessment also highlighted a need for contextualisation to the Irish healthcare system. In conclusion, the plan for Ireland is to adapt rather than simply adopt existing guidelines.

Implementation of a quit smoking programme in community adult mental health services – a qualitative study

Burns A, Webb M, Stynes G, O'Brien T, Rohde D, Strawbridge J, et al. (2018) *Frontiers in Psychiatry*, 9: 670.
<https://www.drugsandalcohol.ie/30227/>

This study aimed to review the implementation of a smoking cessation programme across 16 community mental health day services.

In conclusion, although this group-based cessation programme in community mental health settings was well-received overall, a number of key barriers persist. A joined-up approach which addresses the culture of smoking in mental health settings, inconsistencies in smoking policies, and provides consistent cessation support is needed. Care needs to be taken with the timing as overall it may not be helpful to introduce a new smoking cessation programme at the same time as a tobacco free policy.